A STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON AWARENESS AND READINESS TO CHANGE THE ABUSIVE BEHAVIOR AMONG PERSONS WITH ALCOHOL USE IN SELECTED COMMUNITY AT COIMBATORE.

Ms.K.BANUPRIYA

Reg. No: 301632951

A Dissertation Submitted to

The Tamil Nadu Dr. M. G. R. Medical University,

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INTERNAL EXAMINER **EXTERNAL EXAMINER**

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APPROVED BY THE DISSERTATION COMMITTEE

RESEARCH GUIDE: _____

Prof.Dr.D.CHARMINI JEBAPRIYA,M.Sc(N).,M. Phil,Ph.D,.
Principal,
Texcity college of nursing
Coimbatore -23

SUBJECT GUIDE: _____

Asst Prof.Mrs. A.Vedha Darly., M.Sc(N).,
Texcity College of Nursing
Coimbatore -23

MEDICAL GUIDE: _____

Dr.Mrs.HEMALATHA RAJMOHAN.M.B.B.S.DPM.
Consultant Psychiatrist,
Kurinchi Hospital,
Coimbatore-14

CERTIFICATE

Certified that this is the bonafide work of **Ms.K.Banupriya** Texcity College of Nursing, Coimbatore-23, submitted as a partial fulfillment of the requirement for the **Degree of Master of Science in Nursing** to The **Tamilnadu Dr.M.G.R. Medical University, Chennai**. Under the **Registration No: 301632951**

College Seal

Prof. Dr.D.CHARMINI JEBAPRIYA, M.Sc (N)., M.Phil, Ph.D.,
Principal
Texcity College of Nursing,
Coimbatore-23.

Texcity College Of Nursing
Podanur Main Road
Coimbatore-23.

2018

DECLARATION

I hereby declare that the dissertation entitled **a study to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in selected community at Coimbatore.** Submitted to the Tamilnadu, Dr. M.G.R. Medical University, Chennai, in partial fulfillment of the requirements for the award of the degree of Master of Science in Nursing is a record of original research work done by myself.

This is the study under the supervision and guidance of **Prof. Dr. D. Charmini Jeba Priya, M.Sc(N).,M.Phil,Phd.,** Principal, Texcity College of Nursing, Coimbatore-23 and the dissertation has not found the basis for the award of any degree/ diploma/associated degree/ fellowship or similar title to any candidate of any university.

SIGNATURE OF THE PRINCIPAL

CANDIDATE: Ms.K. BANUPRIYA

DEDICATION

THIS DISSERTATION IS

DEDICATED TO

ALMIGHTY GOD,

OUR BELOVED PARENTS,

BROTHERS & SISTERS,

FRIENDS & WELL WISHERS

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ABSTRACT

Statement of the Problem:

A study to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore.

Objectives:

- To assess the awareness about the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.
- To administer the structured teaching programme about the hazards of alcoholism and its management.
- To evaluate the effectiveness of Structured teaching programme regarding the hazards of alcoholism and its management.
- To correlate the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.
- To associate the effectiveness of Structured teaching programme awareness about the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.

Hypothesis:

H1: There will be a significant difference between the pretest and posttest score on awareness about the hazards of alcoholism and readiness to change the abusive behaviour .

H2: There will be a significant association between the effectiveness of Structured teaching programme on awareness and readiness to change the abusive behaviour with selected demographic variables.

Methodology:

One group pre-test and post-test designwas used . The population in the study includes the alcohol abusers in the age group of 20-65 years and who are residing in Podanur community area Coimbatore.The pre-test was done by using the Structured Questionnaire on awareness of the hazards of alcoholism and Modified Socrates readiness to change Questionnaire. Then the structured teaching programme was given on the hazards of alcoholism and its management by the lecture method with audio-visual aids for 45 minutes.Post-test was conducted on the 15th day by using the same questionnaire. **I**nferential and descriptive statistics were used to analyze the statistical values.

Conclusion:

The improvement means a score of awareness of hazards of alcoholism and its management was 11.16 with the standard deviation of 7.32 and the "t" value was 10.77 which was significant at 0.05 level. In case of readiness to change, the mean value was 32.42 with the standard deviation was 22.99 and the "t" value was 9.07 which was significant at 0.05 level. There was a significant positive correlation between awareness and readiness to change the abusive behavior found in the analysis. There was a significant association found between age and post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use.

Recommendations:

- A similar study can be conducted in a large group to generalize the study findings.
- The study can be conducted to assess the attitudes and coping strategy of significant family members involved in the care of alcohol dependents.
- A comparative study can be done between urban and rural areas.
- A quasi-experimental study can be conducted with a control group for the effective comparison.
- This study can be conducted as a descriptive study to assess the extent and nature of abusive behavioral problems of Alcoholics.

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CHAPTER – I
INTRODUCTION

Alcoholism is a worldwide problem not confined either to developed or to developing nations. The adverse consequences of alcohol not only affect the individual user but society as a whole. Alcohol is a major public health problem today. Alcoholism continues to be a growing nuisance among all the strata of the society. Alcohol dependence is one of the most debilitating psychiatric illness affecting 5% of people, who consume alcohol. The prevalence of alcohol abuse has increased over the past 10 years, and the age of initial alcohol use has increased gradually in India. Alcohol dependence is one of the leading causes of disability and has led to increases in the incidence of crime and violence.

1.1 BACKGROUND OF THE STUDY:

According to All Indian Institute of Medical Sciences, New Delhi (2010), Alcoholism is the third largest health problem in India besides next to heart disease and cancer. In India 15 to 20 percent of people take alcohol, over the past 20 years, the number of alcohol users in our country has increased from one in 300 to one in 20. The production and sale of liquor in the whole country have increased almost 20 times. The result is that the liquor habit has increased in a large number. With more than half of all alcohol users in India falling into the criteria for hazardous drinking, alcohol abuse is emerging as a major public- health problem in the country. Officially, Indians are still among the world's lowest consumers of alcohol. Government statistics show only 21% of adult men and around 2% of women have been using. But up to a fifth of this group- about 14 million people are dependent alcohol users require "help".

Protection of populations at high risk of alcohol-attributable harm and those exposed to the effects of harmful drinking by others should be an integral part of policies addressing the harmful use of alcohol. Individuals and families affected by the harmful use of alcohol should have access to affordable and effective prevention and care services. Children, teenagers, and adults who choose not to drink alcoholic

beverages have the right to be supported in their non-drinking behavior and protected from the pressures to drink.

While alcohol can have a very temporary positive impact on a person's mood, in the long term, it can cause big problems for mental health. It's linked to a range of issues from depression and memory loss to suicide1. Alcohol alters brain chemistry. People brain relies on a delicate balance of chemicals and processes. Alcohol is a depressant, which means it can disrupt that balance, affecting our thoughts, feelings, and actions – and sometimes our long-term mental health. This is partly down to 'neurotransmitters', chemicals that help to transmit signals from one nerve (or neuron) in the brain to another. The relaxed feeling people can get when they have that first drink is due to the chemical changes alcohol has caused in their brain. For most of the people, a drink can help to feel more confident and less anxious. That's because it's starting to depress the part of the brain people associate with inhibition. But, as they drink more, more of the brain starts to be affected. It doesn't matter what mood they are in to start with, when high levels of alcohol are involved, instead of the pleasurable effects increasing, it's possible that a negative emotional response will take over. Alcohol can be linked to aggression a person could become angry, aggressive, anxious or depressed. Alcohol can actually increase anxiety and stress rather than reduce it. Alcohol can make people lose their inhibitions and behave impulsively, so it can lead to actions they might not otherwise have taken – including self-harm and suicide. Drinking heavily over a long period of time can also have long-term effects on memory. Even on days when you don't drink any alcohol, recalling what you did yesterday, or even where you have been earlier that day, become difficult.

Most people with alcohol use do not have knowledge about the hazards of alcoholism, those who realize that they are alcoholic and need help, get the best results. The key objective of the psychoeducation is to provide awareness and to motivate for his changing from abusive behavior. The current approach is that alcoholism is to be understood in terms of character and motivation. Motivation through psychoeducation is considered important in the integration of personality and in achieving mental health. Lack of proper awareness about alcoholism has been the failure of alcoholic treatment.

Motivation is recognized as the result of an interaction between the alcohol dependents and those around him/her, motivation, they can be understood not as something one has but rather as something one does. It involves recognizing a problem, searching for a way to change, and the beginning, continuing and complying with that changed strategy.

1.2: NEED FOR THE STUDY

The problem of alcoholism is increasing day by day because of social changes, westernization. It is the major health problem and it is prevalent in all communities, and it is common in all people irrespective of social status that is rich or poor. It affects both the individual and family functioning.

According to World Health Organization (2014), Among all age groups starting from 15 years old, While 5.9% of all global deaths in 2012 were attributable to alcohol, the percentage of alcohol-attributable deaths among males was higher (7.6%) than that of death among females (4.0%). Intentional injuries: alcohol consumption, especially heavy drinking, has been causally linked to suicide and violence (Cherpitel, 2013; Macdonald et al., 2013). Unintentional injuries: almost all categories of unintentional injuries are impacted by alcohol consumption. The effect is strongly linked to the alcohol concentration in the blood and the resulting effects on psychomotor abilities. Injury to other individuals can be intentional, e.g., assault or homicide, or unintentional, e.g., a traffic crash, workplace accident or scalding of a child. Neglect or abuse can affect, for example, a child, a partner or a person in the drinker's care. Default on the social role can involve the drinker's role as a family member, as a friend and/or as a worker. Property damage can involve damage, for example, to clothing, a car or a building. Toxic effects on other individuals include most notably fetal alcohol syndrome (FAS) and preterm birth complications (Foltran et al., 2011). Loss of amenity or peace of mind can influence family members (including children), friends, co-workers, and strangers, who may, for example, be kept awake or frightened by the actions of the drinker. Physiologically, the liver is the main site of alcoholic metabolism; hence it is the most affected organ. Acute intoxication may cause hypoglycemia leading to sudden death. Chronic heavy

drinking for a long period causes gastritis, ulcers, and pancreatitis. Heavy alcohol intake interferes with food digestion and absorption, which leads to vitamin deficiency. Alcohol increases the effects of the CNS depressant like sedatives and hypnotics.

So, imparting knowledge about the treatment of alcohol and drug dependence and the recovery process to a large number of clients is of paramount importance. It requires less degree of specialist time and can conduct by a trained social worker or psychologist in an inpatient or outpatient setting.

Information and education aimed at the general population play an important role in providing skills for responsible decision making about drinking. Educational approaches are most effective when combined with other policy measures. Education around alcohol consumption is, therefore, an important tool in prevention and an essential component of health education in general.

People need to know that the abuse of alcoholic beverages is a very serious illness. Society has a right to know that this type of abuse is not normal; it causes enormous hazards to health and to the society and should be treated. The longer an individual stays trapped in addiction the more their life will be destroyed. Escape from this destructive behaviour is only possible when the addict is ready to change. This motivation is brought through psychoeducation which must be strong enough to overcome denial and ignorance about the problem.

1.3 STATEMENT OF THE PROBLEM

A study to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore.

1.4 OBJECTIVES

- To assess the awareness about the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.

- To administer the structured teaching programme about the hazards of alcoholism and its management.
- To evaluate the effectiveness of Structured teaching programme regarding the hazards of alcoholism and its management.
- To correlate the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.
- To associate the effectiveness of Structured teaching programme awareness about the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.

1.5 HYPOTHESIS:

- **H1:** There will be a significant difference between the pretest and posttest score on awareness about the hazards of alcoholism and readiness to change the abusive behaviour .
- **H2**: There will be a significant association between the effectiveness of Structured teaching programme on awareness and readiness to change the abusive behaviour with selected demographic variables.

1.6 OPERATIONAL DEFINITIONS

1.6.1 Assess

The act which is planned by the researcher to evaluate the knowledge of alcohol abusers on hazards of alcoholism and readiness to change of abusive behaviour with alcohol use.

1.6.2 Effectiveness

In this study, it refers to find out an intended outcome of structured teaching programme on creating awareness on hazards of alcoholism and readiness to change the abusive behaviour of the person with alcohol use.

1.6.3 Structured Teaching Programme

It refers to a systematically planned group of instructional design to provide information regarding alcoholism, its causes, hazards, management and prevention of alcoholism by lecture method and with the use of audio-visual aids such as the poster, pamphlets to create awareness and to change alcoholics abusive behaviour.

1.6.4 Awareness

It refers to the understanding and the knowledge of the subjects regarding alcoholism, their causes, hazards, and readiness to change the abusive behaviour as measured by the structured questionnaires.

1.6.5 Readiness to change

It is the process of preparing a person with alcohol use to change the attitude towards drinking and reduce the abusive behaviour by creating awareness on hazards of alcohol use.

1.6.7 Abusive behaviour

It refers to the excessive use of alcoholic beverages by a person, either on individual occasions or as a regular practice.

1.6.8 Persons with alcohol use

It refers to both gender in the age group of 20 to 65 years who use alcoholic beverages at least more than 8 times a month or excess.

1.7 ASSUMPTIONS

- Alcoholics have inadequate knowledge regarding alcoholism, causes, hazards, management and awareness and readiness to change their abusive behavior.

- Alcoholics knowledge regarding alcoholism, causes, hazards, management, and prevention of alcoholism will help them to create an awareness and readiness to change their abusive behavior.

- Structured teaching programme will enhance the alcohol abuser's knowledge and help them to create an awareness of the hazards of alcoholism and readiness to change the abusive behavior.

1.8 DELIMITATIONS:

Alcoholics

- who are residing in Podanur community area.
- who are willing to participate in the study.
- who are available at the time of data collection.

1.9 LIMITATIONS:

- The size of the sample is only 50. Hence the study findings cannot be generalized.
- The study was limited to one month, improvement in knowledge takes place slowly.
- The study did not use any control group. There was a possibility of a threat to internal validity, such as events occurring between pretest and post-test session like mass media or other people can influence the Alcohol abuser’s Knowledge.
- The study finding was limited to the alcohol abusers who are residing in Podanur community area. Hence, the findings can be generalized only to the selected community.

1.10 PROJECTED OUTCOMES

This study will enable the investigator to know

- How to improve the knowledge of Alcoholics regarding alcoholism, causes, hazards, management, and prevention of alcoholism will help them to create an awareness and readiness to change their abusive behavior.
- Find out the personnel compelling motivators for change in their attitude.

1.11 CONCEPTUAL FRAMEWORK

The conceptual framework is the interrelated concepts or abstractions that are assembled together in some rational scheme by virtue of their relevance to the common theme. (Nancy burns, 2007).

In this study, a conceptual framework is based on Peplau's interpersonal relation model (1993). Peplau's based her model on psychodynamic nursing, which she defines as using an understanding of one's own behavior to help others identify their difficulties. Psychodynamic Nursing applies principles of human relations to problems that arise at all levels of human relations to problems that arise at all levels of human experience.

In **Peplau's model**, the phase of the nurse-patient relationship reflects the occurrence in personal interactions. The four phases are orientation, identification, exploitation, and resolution. During these phases, the nurse assumes various roles, such as the teacher, Resourcer, counselor, leader, technical expert, and surrogate.

Orientation

The orientation phase begins when a patient expresses the felt need. The researcher establishes the good rapport with the clients and maintains a trustworthy relationship with the subjects. The researcher and the patient meet as strangers and strive to become comfortable with each other which allows the patient to direct energy towards constructive activities.

Identification

In the identification phase, the person with alcohol use and the investigator continue to clarify each other's perceptions and expectations because these determine their personal reactions. In this study, the investigator assesses the demographic variables such as age, sex, religion, educational status, occupation, income, marital status, type of family and location of residence. The level of awareness about alcoholism was assessed using **awareness about alcoholism questionnaire** and scored as inadequate awareness, moderate awareness and adequate awareness and their readiness to change from alcoholism was assessed using **Modified Socrates readiness to change questionnaire** and scored as low readiness to change, moderate readiness to change and high readiness to change.

Exploitation

In the exploitation phase, the investigator assists the group of person with alcohol use. Structured teaching programme was given on alcoholism, its risk factors, causes, pathophysiology and management of alcoholism like lifestyle modifications, diet, medications, and home care remedies, medical and psychiatric care services are taught to the subjects to raise their awareness of alcoholism and assess their readiness to change from alcoholism. In exploitation participate towards abstinence from alcoholism to reduce major health problems, shows regular focus for sleeping, attainment of normal mood, express the feeling verbally, relieve misbehavior, adapt socially acceptable sexual behaviour, engage in social interaction and learn the problem-solving skill.

Resolution

During the resolution phase, after the patient's needs have met by the collaborative efforts of the nurse and the patient, the therapeutic relationship ends. The output is the increasing level of awareness and their readiness to change from alcoholism.

The resolution includes three levels, inadequate awareness and low readiness to change from alcoholism, moderate awareness and moderate readiness to change from alcoholism and adequate awareness and high readiness to change from abusive behavior. An individual with inadequate awareness and low readiness to change from alcoholism is again reassessed and education was given.

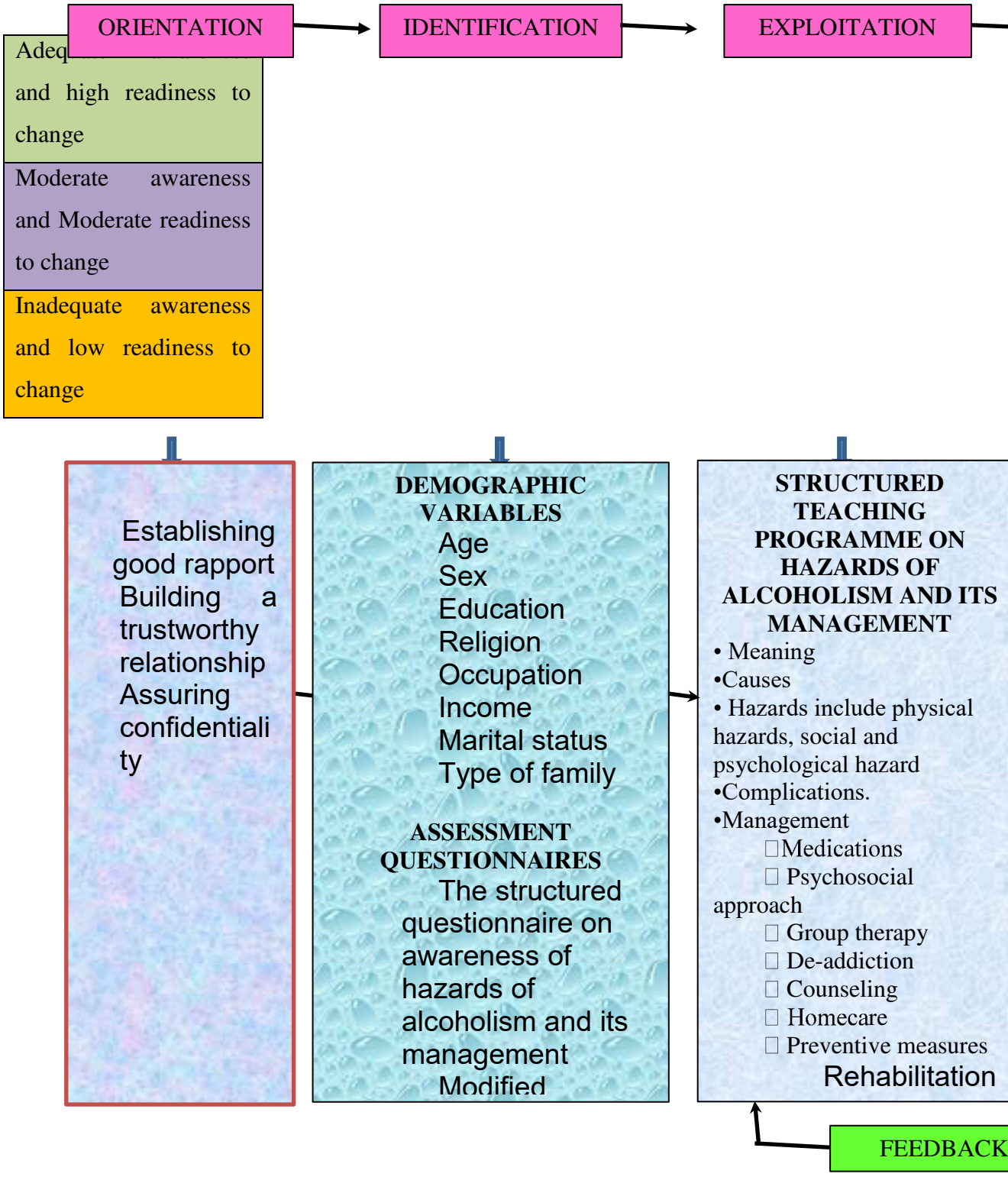

Figure 1.1: MODIFIED E. HILDEGARD PEPLAU'S INTERPERSONAL T

CHAPTER- II
REVIEW OF LITERATURE

Review of literature is an essential aspect of a research work. It is of great help to the researcher and works as a guide for the researcher. Review of related literature serves as a pointer to the lacuna in the concerned piece of research work. The review of literature may not be systematic but it has been done in such a way to indicate and elaborate the causes, problems, consequences, and various contributions in the field of drug and alcohol-related problems. The following are the related literature that the researcher has taken the initiative in providing the basic information on the related research topic.

The review of literature is discussed under the following headings

2.1: Section – A: Literature related to alcoholism

2.2: Section –B: Literature related to awareness of alcoholism and readiness to change the abusive behavior.

2.3: Section – C: Literature related to the effectiveness of Structured teaching programme on alcoholism

2.1: Section – A: Literature related to alcoholism

Ahuja, (2003) The problems of alcoholism – in terms of personal misery, family budget, family discord, loss of wages, failure of health, accidents and cost in damage claims, cost of hospital treatment, cost of custodial treatment in jail, monetary damage in the courts, and inducement to crime – are almost disastrous. Social deviance and social problems emerge from the use and abuse of alcohol. Though the number of annual arrests for public drunkenness is not much in our country, it is a known fact that a large number of alcoholics are not arrested because of the fact that arrest is not considered a good solution to the problem. A good number of persons arrested for crimes like rape, burglary, murder, and theft are those who committed

them while under the influence of alcohol. Alcoholism is a major factor in highway accidents. Besides, it contributes to thousands of deaths every year.

Peschke, (2004) One of the important social problems is the greatest loss of life and property due to Automobile accidents and many fatal accidents on the roads is caused by drinking. In the words of Richards Cabot, "The excessive drinker does not usually drive when s/he is drunk. Moderation is thus more dangerous than excessive drinking as a cause of automobile accidents.

Sharma, R. N. (2005), illustrates that the excessive drinking robs the man of his sense of discrimination; he is unable to distinguish between good and bad, right and wrong. Lal,(2005) indicates that the constitution of India under Article 47, enjoins that the state shall endeavor to bring about prohibition of the consumption, except for medical purposes, of intoxicating drinks and of drugs which are injurious to health.

Mohan, (2008) A study was conducted about Alcohol abuse in a rural community in India: Part II characteristics of alcohol users. About 50% of both male and female users were between 20 and 39 years of age; 8.1% of males and only 1.3% of females used alcohol daily or several times in a week. Desi (country) liquor was the beverage used by more than 85% of the users; 77.5% of males and 96.5% of females consumed less than one-quarter of a bottle of alcohol, and 65.3% of males and 93.6% of females were taking alcohol at their houses only. The reasons given for drinking by the majority of users were 'for pleasures', 'for the celebration of an event' and 'status symbol'. The quantity/frequency index analysis showed that the percentage of alcoholics was 4.2 and the remaining were social drinkers. Physical, economic and social problems were reported by a significantly higher percentage of alcoholics than social drinkers.

Ahluwalia, (2009) Alcohol is known to damage cells, activates chemical carcinogens, causes nutritional deficiencies, and decreases the body's ability to fight cancer and other ailments. An important disadvantage of consuming alcohol is that it suppresses the immune system which is immensely important for an HIV infected person.

According to World Health Organization (2014), Globally, harmful use of alcohol causes approximately 3.3 million deaths every year (or 5.9% of all deaths), and 5.1% of the global burden of disease is attributable to alcohol consumption. Worldwide about 16.0% of drinkers aged 15 years or older engage in heavy episodic drinking. The harmful use of alcohol is a component cause of more than 200 diseases and injury conditions in individuals, most notably alcohol dependence, liver cirrhosis, cancers, and injuries. In 2012, about 3.3 million deaths, or 5.9% of all global deaths, were attributable to alcohol consumption. 7.6% of all male deaths in 2012 were attributable to alcohol, compared to 4.0% of female deaths. The vulnerability of females to alcohol-related harm is a major public health concern. Further, the individual(s) affected may be a spouse or partner, child, relative, friend, neighbour, co-worker, person living in the same household, or a stranger, as is particularly common in the case of traffic crashes.

Arthur, (2012), said that it is generally accepted the around 2-5% of the adult population show major signs of alcohol dependence, that alcohol-related harm is experienced by up to 20% of the population, and that approximately 60% drinkers at risk-free levels. Further prevalence studies show that there are high numbers of problem drinkers who attend general hospital services for reasons other than their alcohol consumption. Nurses are in constant contact with patients who may have an early problem with alcohol, but who are admitted for other reasons, and they are in a prime position to comprehensively assess patients (including alcohol screening), develop rapport and provide 'counseling'. Also, university nursing education is propelling nurses toward the adoption of an independent discipline focused model of care which are increasingly becoming independent of the medical model. Recent trends in the management of problem drinkers suggest that controlled drinking approaches may well offer treatment options for nurses that the traditional abstinence approaches did not. Some recent clinical initiatives are discussed which highlight the flaws existing in nursing education, including lack of sufficient curriculum hours and the need for better-designed education models and strategies.

2.2: Section –B: Literature related to awareness of alcoholism and readiness to change the abusive behavior.

Amanda Baker. et al., (2005) assessed the effectiveness of a motivational interview among hospitalized psychiatric patients with comorbid substance use disorder in reducing alcohol and other drug use. Subjects were assigned randomly to receive an individual motivational interview or a self- help booklet. The findings showed that there was a modest short-term effect of the motivational interview on an aggregate index of alcohol and other drug use.

Edmond Ali., (2006) stated that awareness of self- change as a pathway to recovery for alcohol abusers. Results from five different groups of subjects, however, suggest that most people are unaware of this fact. Reasons for this lack of awareness are decreased exposure and suggestions are made as to the implications of increasing the public' awareness about self- changes as a way of recovering from alcohol problems.

Hausen.S.et al.,(2006), examined motivational readiness to change, drinking behaviour, severity of alcohol and drug use problems, demographic characteristics and whether the level of perceived self-efficacy was associated with aftercare among 220 alcoholics aged 20-66 years, finding revealed that subjects who felt more confident in their ability to handle mood-related and social pressure to drink were more likely to contact after sheds.

Coholic.D., (2010), studied the helpfulness of spiritually influenced group work in developing self- awareness, and self- esteem. The overall purpose of the group was to help alcohol abusers to develop their self- awareness and self- esteem. Grouped therapy analysis of group sessions and individual interviews with the participants found that the participants perceived the group therapy was helpful in developing their self- awareness, and self- esteem.

Stephen Rollnick., (2010) studied that development of a short "readiness to change" questionnaire for use in brief, opportunistic interventions among excessive drinkers. On this basis, a 12- item "readiness to change" questionnaire was developed

with satisfactory psychometric properties. Concurrent validation by comparison with subject's choices of cartoons depicting each of the stages of change and with screening questions regarding aspects of drinking behavior was moderate to very good.

Bradizza .C.M., et al.,(2010) studied alcohol cue reactivity and private self-consciousness among male alcoholics. A cue reactivity assessment was administered to 47 men diagnosed as alcohol dependence. The results suggested that individuals with high private self- consciousness may benefit more from cue exposure-based treatment, as they are more likely to be urged reactors and to evidence negative mood reactivity.

Tamerin .J.S., et al.,(2010) studied the awareness of risk and personal relevance in alcoholism. Self- testing kit was administered to 61 alcoholic patients to assess respondent's attitudes towards excessive drinking and its consequences. The results indicated that during sobriety these alcoholics definitely acknowledged the health hazards of excessive drinking, the seriousness of the problem, its personal relevance and the value of stopping.

Maisto, Stephen, et al.,(2011), studied the effects of education and readiness to change on alcohol use in hazards of alcohol users. The study evaluated the effect of brief advice and motivational enhancement intervention on alcohol consumption. 30 patients who presented for treatment participated in the study. And it was concluded that brief advice through education seemed more effective for relatively low in readiness to change compared to those higher in readiness.

2.3: Section – C: Literature related to the effectiveness of structured teaching programme on alcoholism

Kamins.et al., (2010) studied the cognitive behavioural coping skills and psychoeducation therapies for a person with alcohol use. The study compared the efficacy of cognitive behavioral therapy and psychoeducational therapy for a person with alcohol use. Eighty- eight consecutively referred predominantly diagnosed person with alcohol use were randomized to eight-week session. And the study

concluded that cognitive behavioural therapy subjects exhibited significantly lower rates of relapse than did psychoeducational therapy subjects at 3- month follow up evaluation. Psychoeducational therapy was more effective in relapse of alcohol than cognitive behavioural therapy.

Long shore. D.et al., (2011) stated that motivation for alcohol-abusing through education is widely regarded as crucial to a client's engagement in treatment and success in quitting alcohol use. Motivation is typically measured with items reflecting high treatment readiness and low treatment resistance. This was examined for a 1295 alcohol use samples. Interviews occurred at predicted treatment during the 6 month period. The finding suggests that readiness and resistance should both be assessed among clients entering treatment, especially when the referral is coercive.

Erimybreckmann. (2011), studied about stabilization of abstinence by means of education for patients with the alcoholic liver disease. A manual six- week psycho-educational motivation was conducted in patients with the alcoholic liver disease. 98 of them participated in the group therapy and alcohol abstinence was measured in each session by measuring the alcohol concentration in breath. The study concluded that the therapy rate here facilitated a rehabilitation of mental well being and the relapse was reduced through psychoeducation.

Saitz.R., (2011), studied education for medical inpatients with unhealthy alcohol use. 341 medical in patients who were drinking risky amounts of alcohol was selected. A 30- minute session of motivational counseling given and the study concluded that psychoeducation was sufficient for medical inpatients to motivate for the with treatment for alcohol dependence and for changing alcohol consumption.

Slaski.S.zylick., (2011) studied the effect of psychoeducation on self-awareness in alcoholics. Changes in self- awareness in male alcoholics are measured before and after psychoeducation based on alcoholics anonymous principles. The results show significant recovery from alcoholism and expected changes and an effect of motivation on psychoeducation was also identified.

Gopi, Deepa (2017) conducted a descriptive study on the effectiveness of "structured teaching programme on Knowledge and Attitude towards Alcohol Abuse among Adolescent Boys" at chova higher secondary school at Kannur among 100 higher school boys. Samples were selected by using the convenient sampling technique. The results of this study showed that school students, in general, lacked knowledge and attitude (pretest knowledge score is 8.69 and attitude score is 24.98) about alcohol abuse and its adverse effects before the education programme. The findings of this study support the need for conducting educational programme to increase the knowledge and attitude (post-test knowledge score and attitude score is 16.69 and 44.45, t value is 18.937 with regard to knowledge and 29.92 with regard to attitude which is significant at 0.01 level of school students on alcohol abuse and its related problems.

Snehalatha, Bhagyalakshmi, and Hemalatha, (2017) "A Study to Assess the Effectiveness of Structured Teaching Program on Knowledge Regarding Alcohol Use and Its Harmful Effects Among High School Children at Municipal Corporation School in Tirupati. A quasi-experimental one group pre-test post-test design was used. The pretest means value and standard deviation scores were 15.40+2.499 and the post-test mean value and the standard deviation was 24.08+2.499 and the calculated t-value was 15.846. Findings revealed that there was a significant improvement between pre-test and post-test scores among scores among high school children after the structured teaching program.

CHAPTER III
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The methodology is the way to solve the problem systemically that includes the step of procedure and strategies of the data (Polit and Beck). It includes research approach, research design, the setting of the study, population, sampling size and sampling technique, criteria for the selection of the sample, description of the tool, content validity, reliability, pilot study, data collection procedure and plan for data.

3.2 RESEARCH APPROACH

The quantitative research approach was selected to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore.

3.3 RESEARCH DESIGN

One group pretest, the post-test design was adopted for the present study.

Q1	X	Q 2

- Q1: Pretest assessment
- X : Intervention (video assisted teaching on lifestyle modifications)
- Q2 : Post test assessment

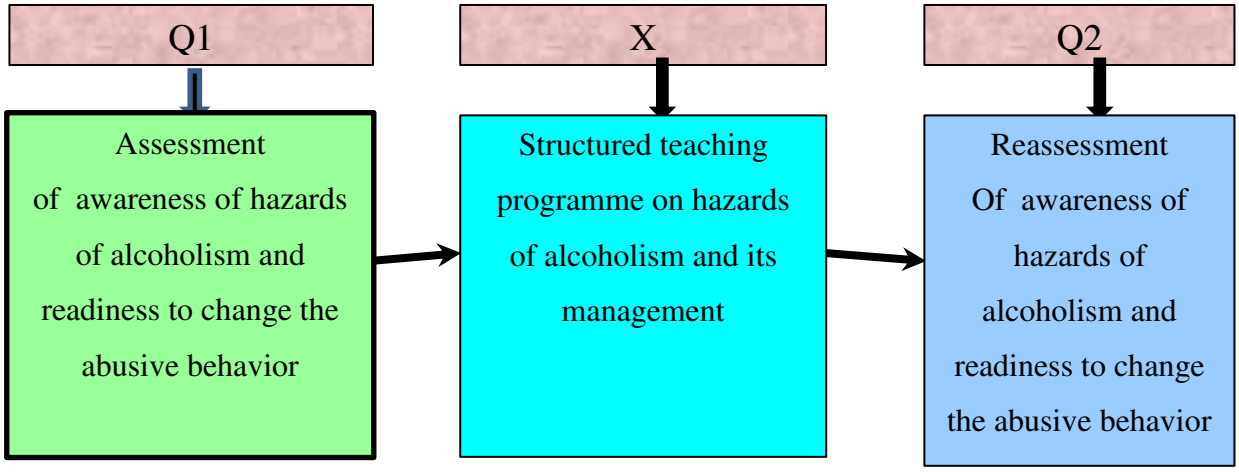

Figure: 3.1: The Schematic Representation of Research Design

3.4 RESEARCH VARIABLES

The Independent variable was a structured teaching programme regarding lifestyle modifications. The dependent variables were awareness of hazards of alcoholism and readiness to change the abusive behavior. Influencing variables were demographic variables.

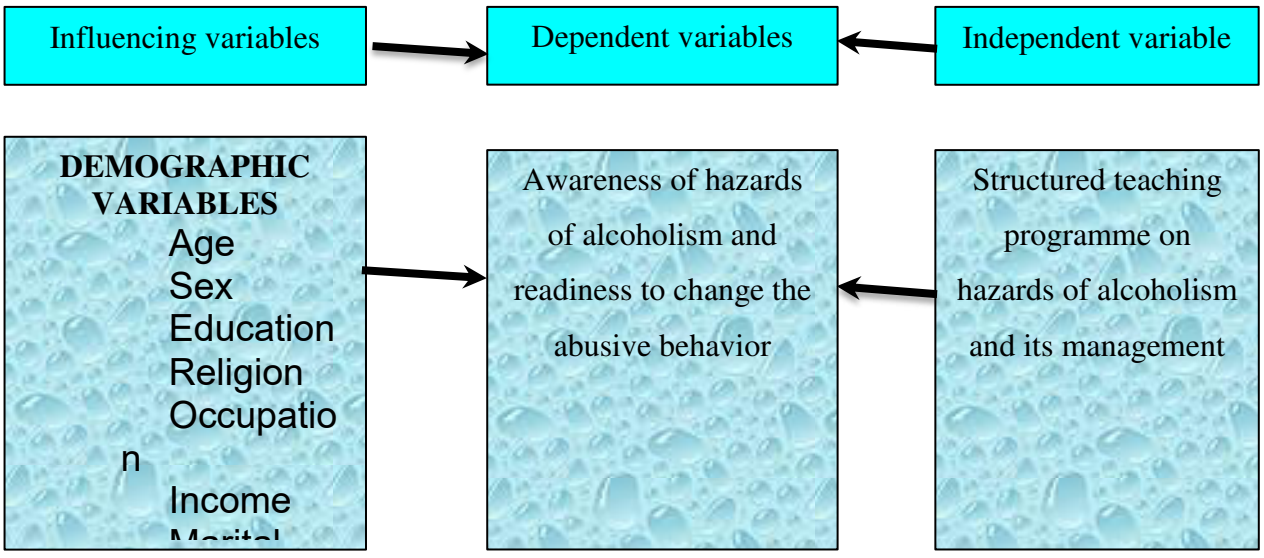

Figure 3.2: The Schematic Representation of Research variables

3.5 THE SETTING OF THE STUDY

The study was conducted to the alcohol abusers who are residing in Podanur community area Coimbatore.

3.6 POPULATION

The population in the study includes the alcohol abusers in the age group of 20-65 years and who are residing in Podanur community area Coimbatore.

3.7 SAMPLES AND SAMPLE SIZE

The sample size is 50 alcohol abusers and who full fill the inclusion criteria.

3.8 CRITERIA FOR THE SELECTION OF SAMPLING

3.8.1 Inclusion Criteria

- Persons who are in the age group of 20- 65 years.
- Persons who can able to speak Tamil /English
- Persons who are currently using alcohol.
- Persons who are willing to participate in the study

3.8.2 Exclusion Criteria

- Persons who have a physical or mental impairment.
- Persons with other kinds of substance use.

3.9 SAMPLING TECHNIQUE

Non -probability convenient sampling technique was used for selecting the samples.

3.10 DESCRIPTION OF THE TOOL

The researcher had developed a structured questionnaire after reviewing the literature. It consisted of 3 sections.

Section -A: Demographic Variables

Demographic variables, which include age, gender, religion, education, occupational status, marital status, Monthly income, and type of family,

Section B: Structured Questionnaire on awareness of hazards of alcoholism.

This section consists of 30 questions to assess the awareness about the hazards of alcoholism among the persons with alcohol use. Each correct answer carries one mark, and the wrong answer carries zero marks. The possible maximum score was 30; the possible minimum score was 0. The rating was given from 1 to 30, to know the awareness about alcoholism.

Table 3.1: Interpretation of Awareness score

S.No	Status of Awareness	Score
1.	Adequate awareness,	21-30
2.	Moderate awareness	11- 20
3.	Low awareness	0- 10

Section- C: Modified Socrates readiness to change Questionnaire

SOCRATES is an experimental instrument designed to assess readiness for change in alcohol abusers. This section consisted of 20 questions on readiness to change the alcohol abusive behavior. For each statement, the rating was given from 1 to 5, to indicate agree or disagree with alcoholism. For each statement, circle one number from 1 to 5, to indicate how much the sample agree or disagree with it right now.

Table 3. 2: Grading of changes to readiness in alcohol abusers

S.No	Changes to Readiness	Statement Score
1.	Strongly agree	5
2.	Agree	4
3.	Undecided	3
4.	Disagree	2
5.	Strongly disagree	1

Table 3. 3: Interpretation of changes to readiness in alcohol abusers

S.No	Interpretation of changes to Readiness	
1.	High readiness to change	70 and above
2.	Moderate readiness to change	40-69
3.	Low readiness to change	20-39

The following is provided as general guidelines for interpretation of scores, but it is wise in an individual case also to examine individual item responses for additional information.

HIGH scorers say that they sometimes wonder if they are in control of their drinking, are drinking too much, are hurting other people, and/or are alcoholic and directly acknowledge that they are having problems related to their drinking, tending to express a desire for change and to perceive that harm will continue if they do not change. They also report that they are already doing things to make a positive change in their drinking, and may have experienced some success in this regard.

Moderate scorers report that they are currently doing things to change their drinking, but not able to control their desire often.

LOW scorers deny that alcohol is causing them serious problems, reject diagnostic labels such as “problem drinker” and “alcoholic,” and do not express a desire for change. LOW scorers say that they do not wonder whether they drink too much, are in control, are hurting others, or are alcoholic.

3.11 TOOL VALIDITY AND RELIABILITY

3.11.1 Content Validity

The standardized tool was obtained and modified by the investigator under the guidance of the experts and based on a review of the literature. Content validity was obtained from the experts in the field of Psychiatry and Psychiatric nursing. All comments and suggestion given by experts were duly considered and corrections were made after discussion with the research guide. The modifications were incorporated in the preparing of final tool.

3.11.2 Reliability

Reliability and scoring practicability was tested through the pilot study and used for the main study. The reliability was checked by the inter-rater method. The reliability score was 0.76. Hence the tool was reliable.

3.12 PILOT STUDY:

A pilot study was conducted to find out the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore, for a period of seven days to find out the reliability and to plan for data analysis. Prior permission from the authorities was obtained and by using simple random sampling technique. Consent was obtained from 5 samples. Structured Questionnaire on awareness of the hazards of alcoholism and Modified Socrates readiness to change Questionnaire was used as an assessment tool. Structured teaching programme was given an awareness of the hazards of alcoholism and its management and readiness to change were assessed. The data were analyzed by using paired ‘t 'test; the calculated value was more than the tabulated value. So, it proved that the effectiveness of the structured teaching programme. The pilot study revealed that the present study was feasible to conduct.

3.13 DATA COLLECTION PROCEDURE

Prior permission was obtained from the concerned authorities. Confidentiality and anonymity of the subjects were maintained. Informed consent was obtained from the respondents and the respondent was selected on the basis of the selection criteria.

On the first day, Demographic data were collected using the Convenient sampling technique. 50 people with alcohol use were screened and selected. The pre-test was done by using the Structured Questionnaire on awareness of the hazards of alcoholism and Modified Socrates readiness to change Questionnaire. Then the structured teaching programme was given on the hazards of alcoholism and its management by the lecture method with audio-visual aids for 45 minutes. The content of the structured teaching programme consisted of alcoholism Meaning, Causes, physical, social and psychological hazards, Complications, Management and Rehabilitation. At the end of the session, pamphlets were distributed to the samples. Post-test was conducted on the 15th day by using the same questionnaire to assess the effectiveness of the structured teaching programme.

3.14 PLAN FOR DATA ANALYSIS

Descriptive statistics, frequency, percentage, mean, standard deviation was used to describe the demographic variables and to describe the pretest and posttest score on awareness of the hazards of alcoholism and readiness to change the abusive behaviour. Inferential statistics, Paired 't' test was used to analyze the effectiveness of structured teaching programme on the awareness and readiness to change the abusive behaviour. The Correlation test was used to analyze the correlation between awareness and readiness to change the abusive behavior. The Chi-square test was used to analyze the association between the selected demographic variables with the post-test score of awareness of the hazards of alcoholism and readiness to change.

3.15 ETHICAL CONSIDERATION

The research was conducted after the approval of the research committee and concerned authorities of the community. The nature and purpose of the study were explained to the authorities of the Podanur community, Coimbatore. Consent was obtained from the participants. The assurance was given to the study samples that the anonymity of each individual was maintained strictly.

CHAPTER-IV
DATA ANALYSIS AND INTERPRETATIONS

This chapter deals with the analysis and interpretation of the data collected from the samples. This study was to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore.

The findings, based on the descriptive and inferential statistical analysis tabulated as follows

- **Section- I:** Frequency and percentage distribution of demographic variables of the persons with alcohol use.
- **Section- II:** Description of statistical value of pre-test and post-test knowledge scores of awareness about hazards of alcoholism among persons with alcohol use.
- **Section - III:** Description of statistical value of pre-test and post-test scores of readiness for change in the abusive behaviour among persons with alcohol use.
- **Section - IV:** Description of statistical value of the mean and standard deviation of pre-test and a post-test score of awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.
- **Section-V:** Improvement score of the awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.
- **Section-VI:** Correlation of post-test scores regarding the awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.
- **Section-VII:** Association between post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use with the selected demographic variables.
- **Section-VIII**: Association between post-test scores regarding readiness for change in the abusive behaviour among persons with alcohol use with the selected demographic variables.

Section- I: Frequency and percentage distribution of demographic variables of the persons with alcohol use.

Table: 4.1 Frequency and percentage distribution of demographic variables of the persons with alcohol use.

n=50

S.No	Demographic Variables	Frequency (f)	Percentage (%)
1	**Age in years**		
	a. <20 years	02	04
	b. 21-40 years	14	28
	c. 41-60 years	30	60
	d. Above 60 years	04	08
2	**Gender**		
	a. Male	47	94
	b. Female	03	06
3	**Religion**		
	a) Hindu	43	86
	b) Muslim	03	06
	c) Christian	04	08
4.	**Education**		
	a) Illiterate	16	32
	b) Primary education	23	46
	c) Secondary education	09	18
	d) Graduation	02	04
5.	**Occupational status**		
	a) Unemployed /student	22	44
	b) Self-employed	15	30
	c) Employed in the private sector	02	09
	d) Employed in the government sector	11	22
6.	**Income/month**		
	a) Less than RS.3000	33	66
	b) Rs 3001-Rs.10,000	15	30
	c) Rs.10,000-Rs.20,000	02	04
	d) d) Above Rs.20,000	0	0
7.	**Marital status**		
	a) Unmarried	05	86
		43	10

	b) Married **c)** Widow/Widower **d)** d) Divorced/Separated	0 02	0 04

S.No	Demographic Variables	Frequency (f)	Percentage (%)
8.	**Type of family** a) Nuclear b) Joint	 43 07	 86 14

From table 4.1, it implies the distribution of respondents according to certain demographic factors like age, sex, religion, education, occupation, income per month, marital status, and type of family.

In case of the religion, 43(86%) Hindus, three (6%) Muslims.

The occupational status of the subjects shows that 22 (44%) farmers, 15 (30%) daily wager, two (9%) students and 11 (22%) others.

Regarding the marital status of the subjects, 43 (86%) got married, five (10%) unmarried, no one was widowed/ widower and two (4%) got divorced and separated.

In the type of family, 43 (86%) belonged to the nuclear family and seven (14%) belonged to the joint family.

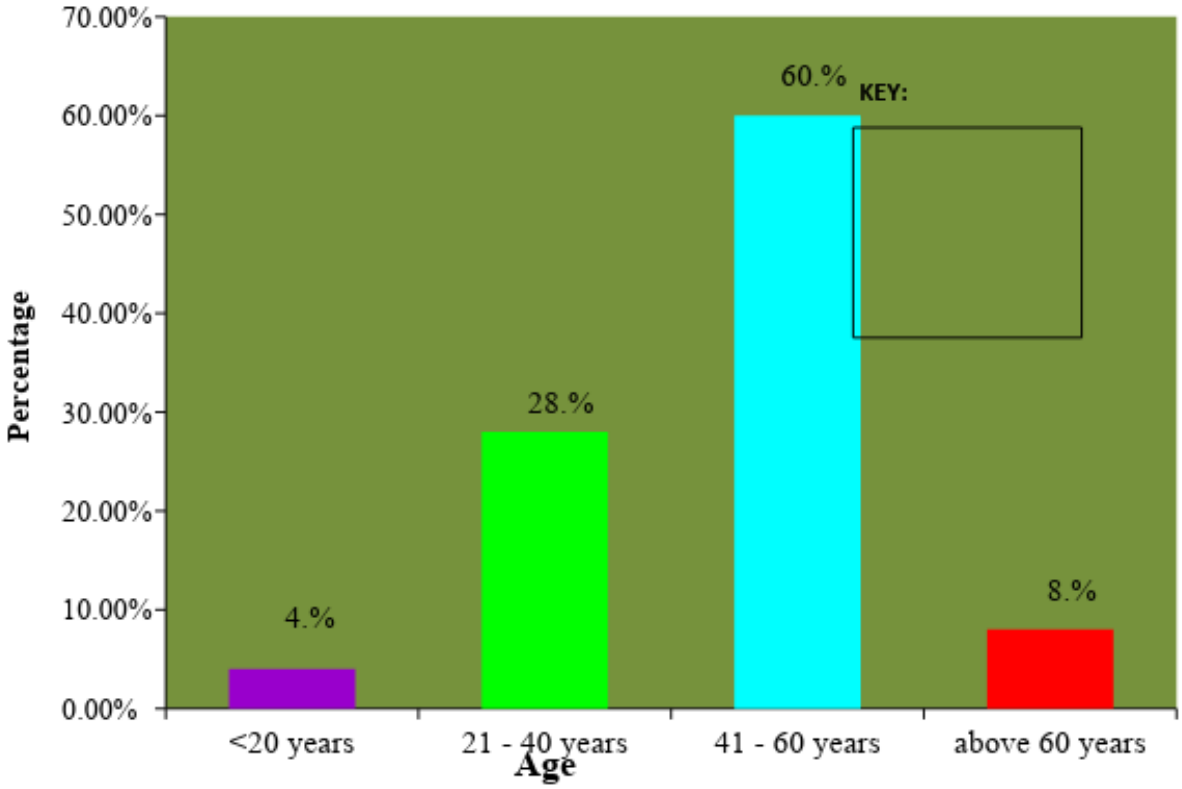

Figure: 4.1.1 Bar diagram shows the percentage distribution of persons with alcohol use based on age

The above bar chart shows that among the 50 persons with alcohol use, two (4%) were in the age group of fewer than 20 years, four(8%) were above 60 years.

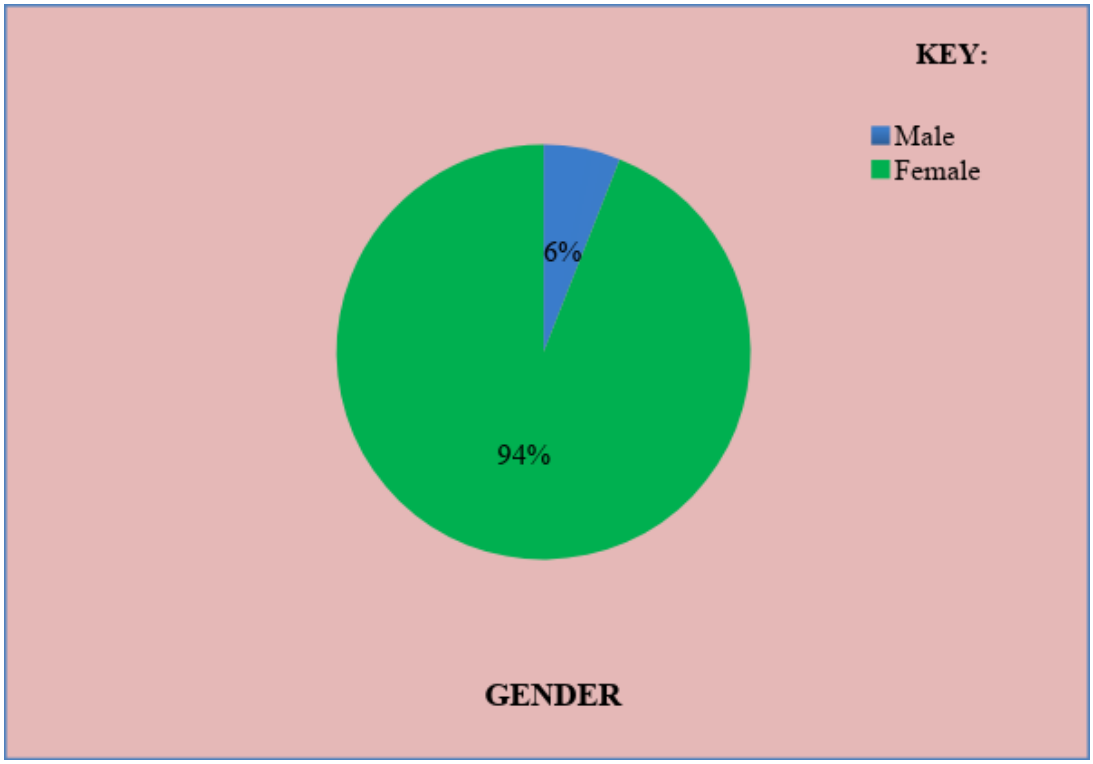

Figure: 4.1.2 Pie chart shows the percentage distribution of persons with alcohol use based on Gender.

The above Pie chart shows that Regarding gender, 47(94%) male and three (6%) female.

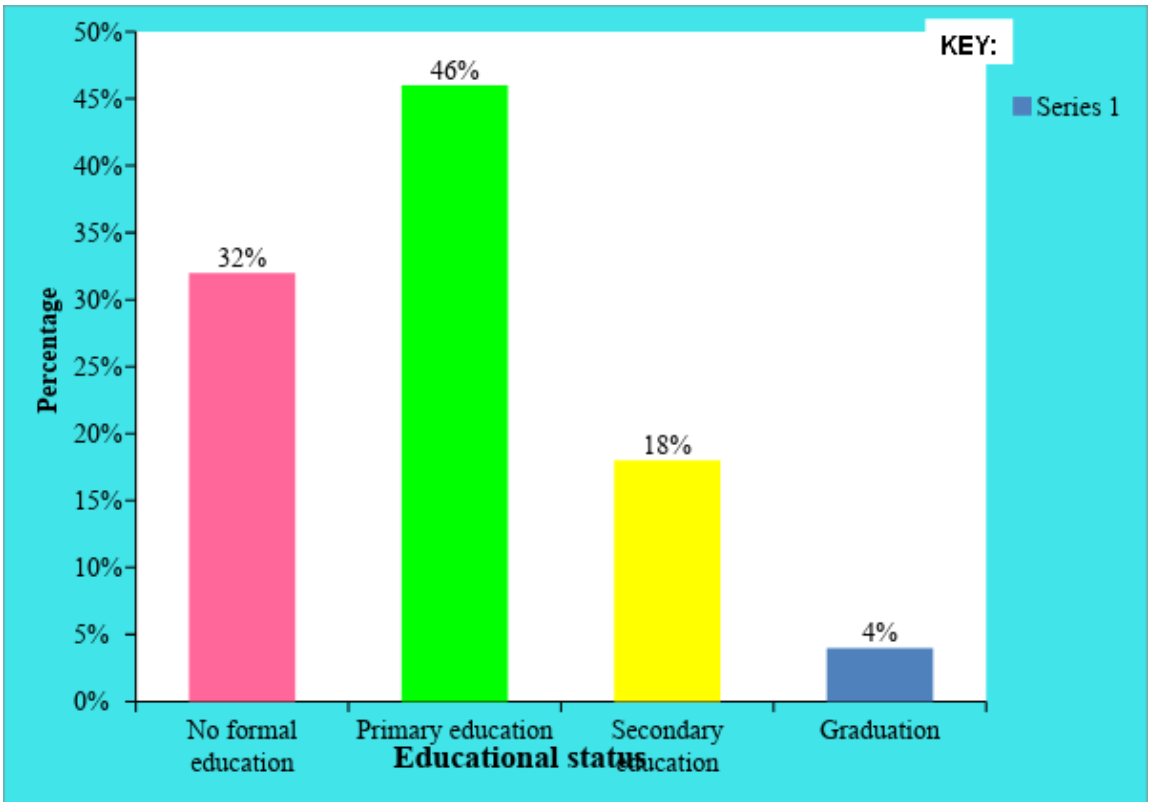

Figure: 4.1.3 Cone chart shows the percentage distribution of persons with alcohol use based on Educational status.

The above cone chart explains that the educational status of the subjects reveals that 16 (32%) were illiterate and two (4%) were graduates 23 (46%) completed primary education and 9 (32%) were finished their secondary education.

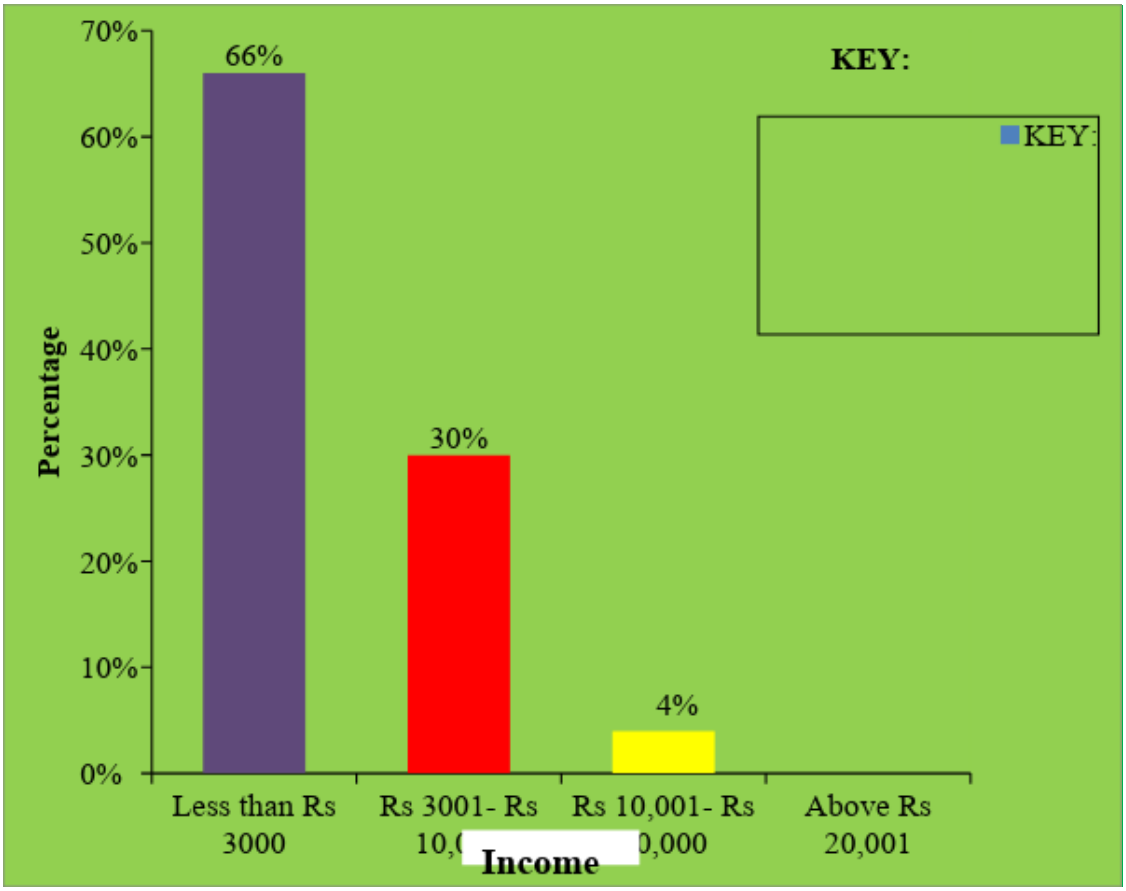

Figure: 4.1.4 Cone chart shows the percentage distribution of persons with alcohol use based on Income.

This cone chart shows that among the 50 respondents, 33 (66%) had the family income of less than Rs. 3000, 15 (30%) had got between Rs 3001-Rs.10,000, 02 (4%) earned Rs.10,000-Rs.20,000 and no one was above Rs.20,000.

Section- II: Description of statistical value of pre-test and post-test knowledge scores of awareness about hazards of alcoholism among persons with alcohol use.

Table: 4.2 Frequency and percentage distribution of pre-test and post-test scores of awareness about hazards of alcoholism among persons with alcohol use

n=50

S.No	LEVEL OF AWARENESS	PRE TEST		POST TEST	
		F	%	F	%
1.	Inadequate awareness	42	84	05	10
2.	Moderate awareness	04	08	10	20
3.	Adequate awareness	04	08	35	70

This table 4.2, shows the comparison between the pretest and posttest score of awareness about the hazards of alcoholism among persons with alcohol use, in which 42 (84%) had inadequate awareness, four (8%) had moderate awareness and four(8%) had adequate awareness about alcoholism in the pre-test. Whereas in post-test the subjects had five (10%) of inadequate awareness, 10 (20%) had moderate awareness and 35 (70%) had adequate awareness about alcoholism after the structured teaching programme.

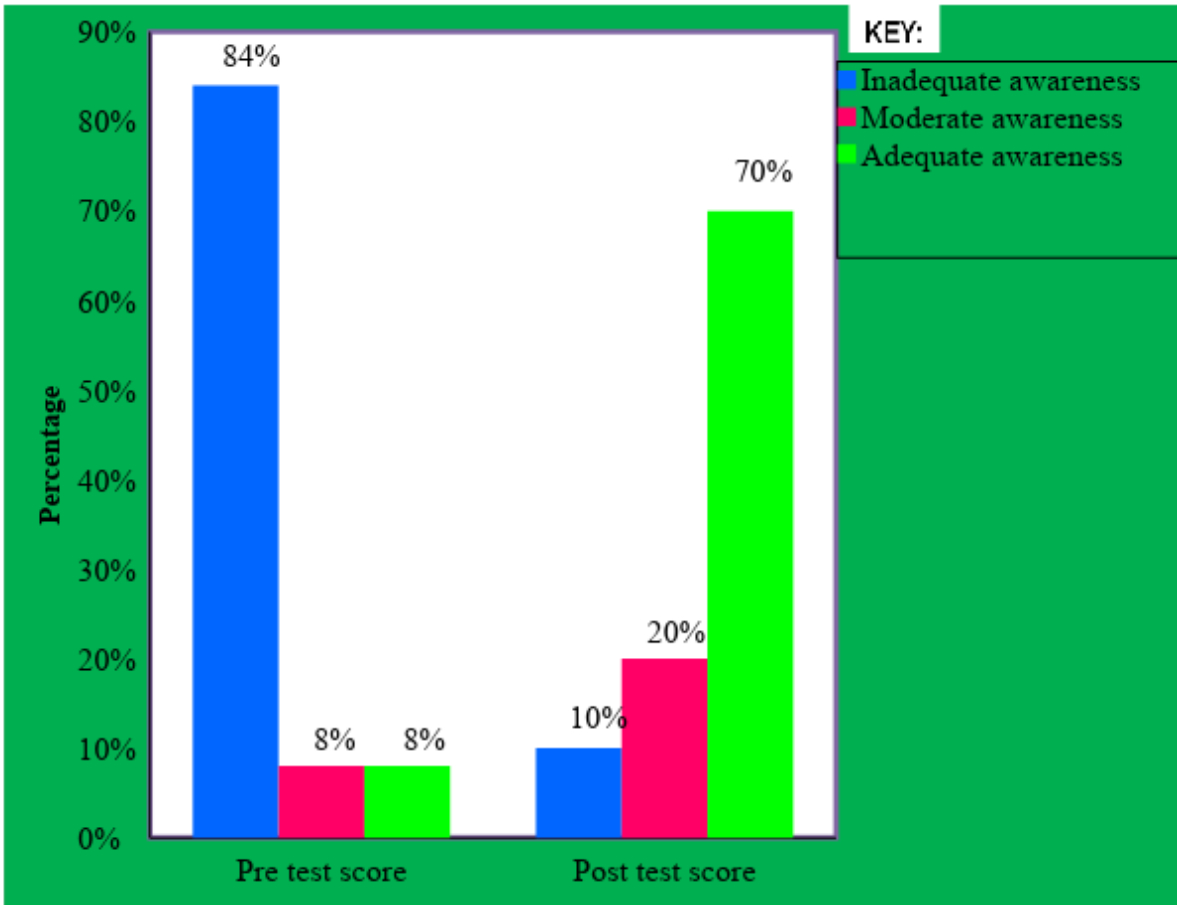

Figure 4.2.1: Cone chart shows the percentage distribution of pre-test and post-test scores of awareness about hazards of alcoholism among persons with alcohol use

Section - III: Description of statistical value of pre-test and post-test scores of readiness for change in the abusive behaviour among persons with alcohol use.

Table: 4.3 Frequency and percentage distribution pre-test and post-test scores of readiness for change in the abusive behaviour among persons with alcohol use.

n=50

S.No	READINESS TO CHANGE	PRE TEST		POST TEST	
		F	%	F	%
1.	Low readiness to change	37	74	10	20
2.	Moderate readiness to change	09	18	07	14
3.	High readiness to change	04	08	3	66

Table 4.3, depicts a comparison between the pretest and post-test score of readiness to change the abusive behaviour among persons with alcohol use. It shows that 37(74%) had low readiness to change the abusive behaviour,9(18%) had a moderate desire to change the abusive behaviour and 4(8%) showing high readiness to change the abusive behaviour, whereas in post-test there were 10(20%) had low readiness to change the abusive behaviour, 7(14%) had moderate readiness to change the abusive behaviour,33(66%) had high readiness to change the abusive behaviour.

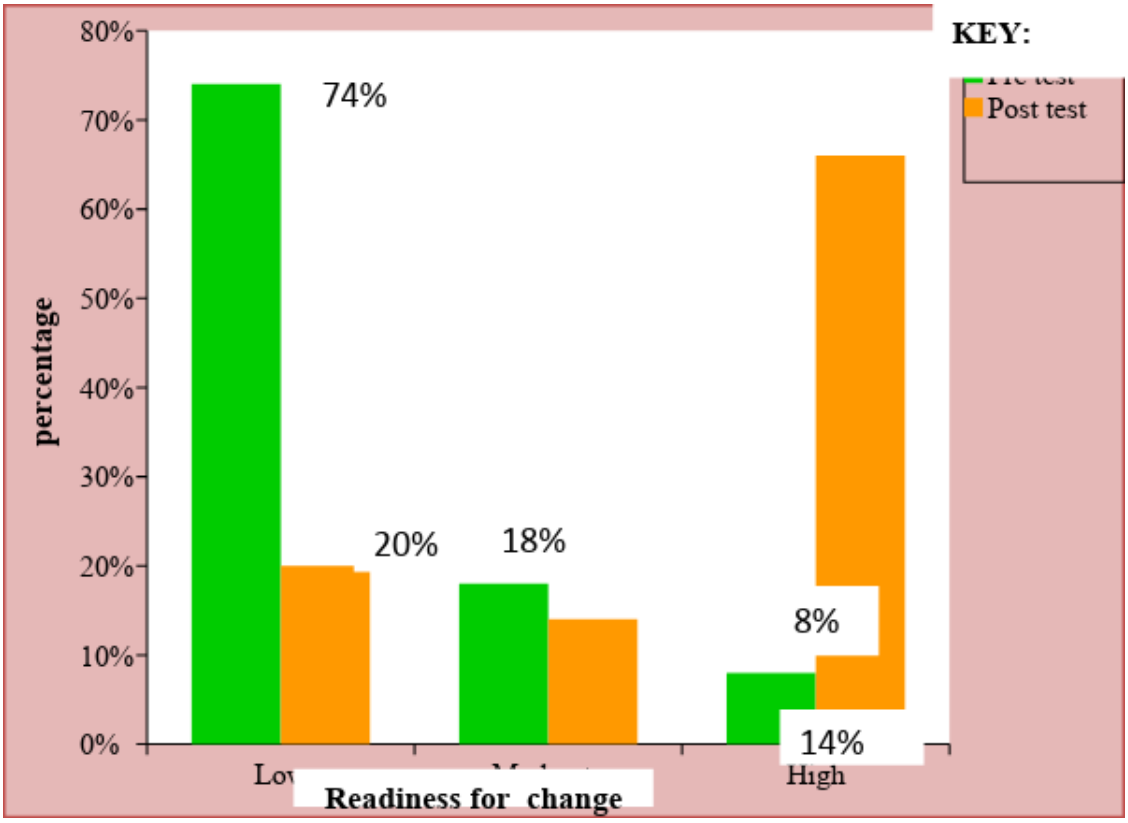

FIG 4.3.1 Cone chrt shows the pre-test and post-test scores of readiness for change in the abusive behaviour among persons with alcohol use.

Section - IV: Description of statistical value of the mean and standard deviation of pre-test and a post-test score of awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.

Table: 4.4 Frequency and percentage distribution of pre-test and post-test scores of awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.

n=50

S.NO	PRETEST AND POSTTEST AWARENESS AND READINESS SCORE	MEAN	STANDARD DEVIATION
1.	Pretest awareness	11.96	5.24
2.	Posttest awareness	23.12	5.41
3.	Pretest readiness	42.96	17.07
4.	Posttest readiness	75.38	19.92

Table 4.4.comparison between the mean and standard deviation of pretest and posttest score of awareness and readiness to change the abusive behaviour. The pre-test awareness mean was 11.96 and the standard deviation was 5.24 and post awareness mean was 23.12 and the standard deviation was 5.41. In case of readiness for change, the pre-test mean was 42.96 and the standard deviation was 17.07 and post-test readiness to change mean was 75.38 and the standard deviation was 19.92.

Section-V: Improvement score of the awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.

Table 4.5: Improvement score of the awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.

n=50

S.NO	SCORE	AWARENESS SCORE			READINESS TO CHANGE SCORE		
		MEAN	S.D	't' VALUE	MEAN	S.D	't' VALUE
1.	Improvement scores	11.16	7.32	10.77*	32.42	22.99	9.07*

*significant at

P<0.05

Table 4.5 reveals the improvement score of the awareness and readiness to change the abusive behaviour among persons with alcohol use. The improvement means score was 11.16 with the standard deviation of 7.32 and the "t" value was 10.77 which was significant at 0.05 level. In case of readiness to change, the mean value was 32.42 with the standard deviation was 22.99 and the "t" value was 9.07 which was significant at 0.05 level. This reveals that the Structured teaching programme was effective in creating awareness and readiness to change the abusive behaviour among persons with alcohol use.

Section-VI: Correlation of post-test scores of the awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.

Table 4.6: Mean, standard deviation and correlation of post-test scores of the awareness about hazards of alcoholism and readiness for change in the abusive behaviour among persons with alcohol use.

n=50

S. No	Post Test Score	Mean	Standard Deviation	"r"
1	Awareness Score	23.12	5.41	0.234
2	Readiness Score	75.38	19.92	

Table 4.6 Karl Pearson coefficient of correlation was used. The table shows that the awareness means score was 23.12 with the standard deviation of 5.41. In case of readiness to change, the mean value was 75.38 with the standard deviation of 19.92 and the "r" value was 0.234. Thus, there is a significant positive correlation between awareness and readiness to change the abusive behaviour.

Section-VII: Association between post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use with the selected demographic variables.

Table 4.7: Frequency, percentage, and $\chi 2$ of post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use with the selected demographic variables.

n=50

S.NO	DEMOGRAPHIC VARIABLES	POSTTEST AWARENESS						
		Inadequate		Moderate		Adequate		$\chi 2$
		F	%	F	%	F	%	
1	**Age**							
	a) < 20 years	0	0	02	0.4	0	0	
	b) 21-40 years	01	0.2	02	0.4	11	2.2	9.45*
	c) 41-60 years	04	0.8	05	01	21	4.2	**S**
	d) Above 60 years	0	0	01	0.2	3	0.6	
2.	**Gender**							
	a) Male	05	01	10	02	32	6.4	1.36
	b) Female	0	0	0	0	03	0.6	**NS**
3.	**Religion**							
	a) Hindu	02	0.4	09	1.8	32	6.4	
	b) Muslim	01	0.2	01	0.2	01	0.2	11.27
	c) Christian	02	0.4	0	0	02	0.4	**NS**
	d) Others	0	0	0	0	0	0.1	
4.	**Education**							
	a) Illiterate	0	0	04	0.8	12	2.4	
	b) Primary level	04	0.8	02	0.4	14	3.4	6.92
	c) Secondary level	01	0.2	03	0.6	05	1	**NS**
	d) Graduation	0	0	01	0.2	01	0.2	

5.	**Occupation**							
	a) Farmers	03	0.6	03	0.6	16	3.2	
	b) Daily Wages	0	0	02	0.4	13	2.6	7.55
	c) Student	0	0	01	0.2	01	0.2	**NS**
	d) Others(specify)	02	0.4	04	0.8	05	01	
6.	**Income**							
	a) Less than Rs. 3000	03	0.6	05	01	25	05	
	b) Rs. 3001-Rs10,000	02	0.4	05	01	08	1.6	3.52
	c) Rs.10,000-	0	0	0	0	02	0.4	**NS**
	Rs.20,000	0	0	0	0	0	0	
	d) Above Rs.20,000							

S- Significant **NS-Non significant**

Table 4.7 • The $\chi 2$ test was used to find out the association. This table states that there was a significant association found between age and post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use and also reveals that there was no significant association found between demographic variables such as gender, religion, education, occupation, income post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use.

Section-VIII: Association between post-test scores regarding readiness for change in the abusive behaviour among persons with alcohol use with the selected demographic variables.

Table 4.8: Frequency, percentage, and $\chi 2$ of post-test scores regarding readiness for change in the abusive behaviour among persons with alcohol use with the selected demographic variables.

n=50

S.NO	DEMOGRAPHIC VARIABLES	POSTTEST AWARENESS						
		Inadequate		Moderate		Adequate		χ2
		F	%	F	%	F	%	
1	**Age**							
	a) < 20 years	0	0	0	0	02	04	
	b) 21-40 years	03	06	0	0	11	22	4.826
	c) 41-60 years	06	12	06	12	18	36	**NS**
	d) Above 60 years	01	02	01	02	02	04	
2.	**Gender**							
	a) Male	08	16	07	14	32	64	4.438
	b) Female	02	04	0	0	01	02	**NS**
3.	**Religion**							
	a) Hindu	10	20	04	08	29	58	
	b) Muslim	0	0	02	04	01	02	9.143
	c) Christian	0	0	01	02	03	06	**NS**
	d) Others	0	0	0	0	0	0	
4.	**Education**							
	a) Illiterate	05	10	03	06	08	16	
	b) Primary level	04	08	01	02	18	36	7.961
	c) Secondary level	01	02	03	06	05	10	**NS**
	d) Graduation	0	0	0	0	02	04	

5.	**Occupation**							
	a) Farmers	06	12	02	04	14	28	
	b) Daily Wages	03	06	02	04	10	20	4.063
	c) Student	0	0	0	0	02	04	**NS**
	d) Others(specify)	01	02	03	06	07	14	

NS – Non-significant

Table 4.8 states that there was no significant association found between the selected demographic variables and post-test scores regarding readiness for change in the abusive behaviour among persons with alcohol use.

CHAPTER V
FINDINGS AND DISCUSSION

This is a non-experimental study to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore. The data were analyzed using descriptive and inferential statistics. The result of the study was discussed according to the objective.

The first objective of the study was to assess the awareness about the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.

Table 4.2, shows the comparison between the pretest and posttest score of awareness about the hazards of alcoholism among persons with alcohol use, in which 42 (84%) had inadequate awareness, four (8%) had moderate awareness and four (8%) had adequate awareness about alcoholism in the pre-test. Whereas in post-test the subjects had five (10%) of inadequate awareness, 10 (20%) had moderate awareness and 35 (70%) had adequate awareness about alcoholism after a structured teaching programme.

Table 4.3, depicts a comparison between the pretest and post-test score of readiness to change the abusive behaviour among persons with alcohol use. It shows that 37(74%) had low readiness to change the abusive behaviour,9(18%) had a moderate desire to change the abusive behaviour and 4(8%) showing high readiness to change the abusive behaviour, whereas in post-test there were 10(20%) had low readiness to change the abusive behaviour, 7(14%) had moderate readiness to change the abusive behaviour,33(66%) had high readiness to change the abusive behaviour.

The second objective of the study was to administer the structured teaching programme about the hazards of alcoholism and its management.

Demographic data were collected using the Convenient sampling technique. 50 people with alcohol use were screened and selected. The pre-test was done by using the Structured Questionnaire on awareness of the hazards of alcoholism and Modified Socrates readiness to change Questionnaire. Then the structured teaching programme was given on the hazards of alcoholism and its management by the lecture method with audio-visual aids for 45 minutes. The content of the structured teaching programme consisted of alcoholism Meaning, Causes, physical, social and psychological hazards, Complications, Management and Rehabilitation. At the end of the session, pamphlets were distributed to the samples. Post-test was conducted on the 15th day by using the same questionnaire to assess the effectiveness of the structured teaching programme.

The third objective of the study was to assess assess the effectiveness of Structured teaching programme regarding the hazards of alcoholism and its management

Table 4.4.comparison between the mean and standard deviation of pretest and posttest score of awareness and readiness to change the abusive behaviour. The pre-test awareness mean was 11.96 and the standard deviation was 5.24 and post awareness mean was 23.12 and the standard deviation was 5.41. In case of readiness for change, the pre-test mean was 42.96 and the standard deviation was 17.07 and post-test readiness to change mean was 75.38 and the standard deviation was 19.92.

Table 4.5 reveals the improvement score of the awareness and readiness to change the abusive behaviour among persons with alcohol use. The improvement means score was 11.16 with the standard deviation of 7.32 and the "t" value was 10.77 which was significant at 0.05 level. In case of readiness to change, the mean value was 32.42 with the standard deviation was 22.99 and the "t" value was 9.07 which was significant at 0.05 level. This reveals that the Structured teaching programme was effective in creating awareness and readiness to change the abusive behaviour among persons with alcohol use.

The fourth objective of the study was to correlate the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.

Table 4.6 shows that the awareness means score was 23.12 with the standard deviation of 5.41. In case of readiness to change, the mean value was 75.38 with the standard deviation of 19.92 and the "r" value was 0.234. Thus, there is a significant positive correlation between awareness and readiness to change the abusive behaviour.

The fifth objective of the study was to associate the effectiveness of Structured teaching programme awareness about the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use

Table 4.7 states that there was a significant association found between age and post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use and also reveals that there was no significant association found between demographic variables such as gender, religion, education, occupation, income post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use.

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Table 4.8 states that there was no significant association found between the selected demographic variables and post-test scores regarding readiness for change in the abusive behaviour among persons with alcohol use.

CHAPTER - VI
SUMMARY, CONCLUSION, NURSING IMPLICATIONS LIMITATIONS AND RECOMMENDATIONS

6.1 SUMMARY

The purpose of the study was to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore.

6.1.1 Objectives:

- To assess the awareness about the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.
- To administer the structured teaching programme about the hazards of alcoholism and its management.
- To evaluate the effectiveness of Structured teaching programme regarding the hazards of alcoholism and its management.
- To correlate the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.
- To associate the effectiveness of Structured teaching programme awareness about the hazards of alcoholism and readiness to change the abusive behaviour among persons with alcohol use.

6.1.2 Hypothesis:

H1: There will be a significant difference between the pretest and posttest score on awareness about the hazards of alcoholism and readiness to change the abusive behaviour .

H2: There will be a significant association between the effectiveness of Structured teaching programme on awareness and readiness to change the abusive behaviour with selected demographic variables.

6.1.3 Major Findings of the Study

The pre-test awareness mean was 11.96 and the standard deviation was 5.24 and post awareness mean was 23.12 and the standard deviation was 5.41. In case of readiness for change, the pre-test mean was 42.96 and the standard deviation was 17.07 and post-test readiness to change mean was 75.38 and the standard deviation was 19.92.

The improvement means a score of awareness of hazards of alcoholism and its management was 11.16 with the standard deviation of 7.32 and the “t” value was 10.77 which was significant at 0.05 level. In case of readiness to change, the mean value was 32.42 with the standard deviation was 22.99 and the “t” value was 9.07 which was significant at 0.05 level.

In case of awareness of hazards of alcoholism and its management awareness post test mean score was 23.12 with the standard deviation of 5.41. whereas in readiness to change the abusive behavior, the mean value was 75.38 with the standard deviation of 19.92 and the "r" value was 0.234. Thus, there is a significant positive correlation between awareness and readiness to change the abusive behaviour.

There was a significant association found between age and post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use and also reveals that there was no significant association found between demographic variables such as gender, religion, education, occupation, income post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use.

There was no significant association found between the selected demographic variables and post-test scores regarding readiness for change in the abusive behaviour among persons with alcohol use.

6.2 CONCLUSION

The improvement means a score of awareness of hazards of alcoholism and its management was 11.16 with the standard deviation of 7.32 and the "t" value was 10.77 which was significant at 0.05 level. In case of readiness to change, the mean value was 32.42 with the standard deviation was 22.99 and the "t" value was 9.07 which was significant at 0.05 level. There was a significant positive correlation between awareness and readiness to change the abusive behavior found in the analysis. There was a significant association found between age and post-test scores regarding awareness about the hazards of alcoholism among persons with alcohol use.

6.3 NURSING IMPLICATIONS

Behavioral disorders in children are not cured but must be managed through early identification by timely health education. The findings of the study have implications for nursing practice, nursing education, nursing administration and nursing research.

6.3.1 Nursing Practice

- The present study focuses on the need for working in education programme to create awareness for their motivation to change alcoholic's abusive behavior.
- Nurses can collaborate with the other health team members to provide effective education to the person with alcohol use.
- Nurses need to be trained to handle the person with alcohol abuse.
- Nurses should focus on psychiatric rehabilitation in the community setting by using health teaching regarding alcoholism and its management.

6.3.2 Nursing Education

- Adequate training must be given to the student nurses regarding the hazards of alcoholism and its management.
- Staff nurses can be given in-service education regarding tools to assess the alcoholics and care of patients with alcohol abuse.
- A psychoeducation programme can be conducted for the parents and significant family members involved in the care of alcohol dependents.
- Education regarding Alcoholic Annonymous programme should be given to the public.

6.3.3 Nursing administration

- The findings could be utilized as a basis for in-service education programmes for nurses and health professionals, who are working in hospital and community set up.
- In-service education programmes, conferences, workshops can be organized on various aspects of alcoholism and its management.
- The budget needs to be allocated to organize various services and programmes to reduce alcoholism in the community.
- Incentives and rewards can be given to motivate the nurses to implement and participate in community education programmes.

6.3.4 Nursing research

- The effectiveness of the study can be verified by the nurses in the clinical and community settings.
- The findings of the study could help to expand the scientific body of professional knowledge upon which further investigation can be conducted.
- Further study can be conducted among other types of drug abuse.

6.4 LIMITATIONS

- The size of the sample is only 50. Hence the study findings cannot be generalized.
- The study was limited to one month, improvement in knowledge takes place slowly.
- The study did not use any control group. There was a possibility of a threat to internal validity, such as events occurring between pretest and post-test session like mass media or other people can influence the Alcohol abuser's Knowledge.
- The study finding was limited to the alcohol abusers who are residing in Podanur community area. Hence, the findings can be generalized only to the selected community.

6.5 RECOMMENDATIONS

- A similar study can be conducted in a large group to generalize the study findings.
- The study can be conducted to assess the attitudes and coping strategy of significant family members involved in the care of alcohol dependents.
- A comparative study can be done between urban and rural areas.
- A quasi-experimental study can be conducted with a control group for the effective comparison.
- This study can be conducted as a descriptive study to assess the extent and nature of abusive behavioral problems of Alcoholics.

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REFERENCES

BOOK REFERENCES

1. **FOX DAVID.** Fundamentals of research in nursing. 4th edition. Newyork: Appleton centre crafts;1993.

2. **GEORGE BJ.** Nursing theories the base for professional Nursing practice. 4th edition. California: library of congress;1995.

3. **GUPTA SP**. Statistical methods. 28th edition. New Delhi: Sultanchand and sons publishers; 1998. Haber. Psychiatric nursing. 5th edition. Mosby publications;2000.

4. **HARKNESS G.D**. Total patient care. 10th edition. California: Mosby publications;1999.

5. **JUDD LL,SALETU B, FILIP V**.Basic and clinical science of mental and addictive disorders. First edition.Newyork:1997.

6. **KAPLAN AND SADOCK**. Synopsis of psychiatry, behavioral sciences/ clinical psychiatrics.10th edition. Lippincott Williams and Wilkins;2007.

7. **KOTHARI CR**. Research methodology, methods and techniques. 2nd edition. New Delhi: Wishwaprakasam;1990.

8. **LALITHA K**. Mental health and psychiatric nursing an Indian perspective. 1st edition. Bangalore: VMG Book house;2007.

9. **LARAIA STUART** .Principles and practice of Psychiatric Nursing. 8th edition. Kundli: Elsevier;2005.

10. **LAURA A.** Principles and practice of Nursing Research. Mosby publications;2001.

11. **LOUSIE**. Basic concepts of Psychiatric Mental Health Nursing.7th edition. Newdelhi: Wilkins Williams publishers;2008.

12. **MAHAJA BK**. Methods of Biostatistics. Newdelhi: jaypee brothers publishers;1994.

13. **MARY ANN BOYD**.Psychiatric nursing contemporary practice.3rd edition. Newdelhi: Lippincott publication;2005.

14. **MARY C TOWNSEND**. Psychiatric health Nursing. 5th edition. Newdelhi :jaypee brothers;2006.

15. **MOHR K WANDA**. Psychiatriy Mental health Nursing. 6th edition, Phiadelphia:2006.

16. **MORREN FRISCH**.Principles and practice of Psychiatric Nursing. 2nd edition. Newdelhi: Delmar publishers;2006.

17. **POLIT D.F.** Nursing research principles and methods. 6th edition. Philadelphia: Lippincott;1999.

18. **PORLAND**. Nursing research. 6th edition. Philadelphia: Lippincott publications;2000.

19. **POTTER AP,PERRY AG**.Fundamentals of nursing.4thedition .mosby Louis publications;
2007.

20. **SALLY WECHNEIER** .Oxford advanced learners dictionary. 6th edition. Newyork: oxford dictionary university;2000.

21. **SUSAN BO'S SULLIVAN**.Physical rehabilitation. 5th edition. jaypee brothers;2004.

22. **SHEILA.** Psychiatric nursing.3rd edition. Philadelphia:Lippincott publications;

23. **SREEVANI R**. Psychiatric nursing methods and techniques.2ndedition. , newdelhi:jaypee brothers;2007.

24. **SYMALAN K**.Stastistics in medicine. 1stedition. Trivandrum. global education.2006.

25. **TOWNSEND CM.** Psychiatric health nursing concepts of care. 1st edition. California: library of congress;1993.

JOURNAL REFERENCES:

1. Andreas JB. Fathers heavy drinking pattern and the children'spsychosocial problems.American journal of psychiatric nursing[Internet].2000.Apr[cited 2008 june]; volume 25.

2. Amanda Baker, Terry lewin. Evaluation of a motivational interview for substance use within psychiatric inpatient services. British journal of psychiatry [Internet].2002.Aug [cited 2010 july]; volume 154, no 23.

3. Gopi, Deepa, Effectiveness of Structured Teaching Programme on Knowledge and Attitude towards Alcohol Abuse among Adolescent Boys, Asian Journal of Nursing Education and Research, [Internet]. 2017.apr [cited 2018 july] Volume 7.

4. Balan K. Alcohol consumption and violence, their implications on individual and family health. Journal of psychosocial nursing[Internet].2003. feb[cited 2008 oct]; volume 99.

5. Danis DD. Peer pressure and motivation of alcoholic and drug dependent. Journal of studies on Alcohol, volume 117, no-11, 2007.

6. Fleming et al. Motivational interviewing. Journal of studies in alcohol[Internet]. 2002. mar[cited 2009 sep]; volume 43.

7. Global status report. Alcohol policy. World Health Organization forom[Internet]. 2004.nov[cited 2010 dec];volume 40.

8. Heinemann. Pattern and problems of alcohol consumption in India .World Health Organization, geneva.[Internet].2005. oct[cited 2007 feb];volume 36.
9. Joe WG Simpson. Effects of readiness in drug abuse treatment.[Internet].1998.aug[cited 2002 sep]; volume 9.

10. Jacobwindlle M. Person with alcohol use and their medical problems. British medical journal.[Internet].2008.apr[cited 2010 nov]; volume 33.

11. Longshore D,Teniya C. Treatment motivation in drug users. Journal of substance abuse treatment.[Internet]. 2006 sep[cited 2008 dec]; volume 15.

12. Malamba. Alcoholism and depression. Indian journal of Psychiatry.[Internet]. 2003 aug[cited 2009 dec]; volume 14.

13. Mohan D, Alcohol abuse in India Part II : Characteristics of alcohol users, Drug alcohol Depend" , [Oct 2008] ; 14 (2) : 121-128

14. Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). Psychology of Addictive Behavior 10,81-89

15. Miller WR. Motivation for treatment, a review with special emphasis on Alcoholism. Psychological bulletin.[Internet].2004 jan[cited 2006 apr]; volume 45..

16. Share D, MC Crady B, Epstein E .Stages of change and decisional balance for women seeking alcohol treatment. Journal of addictive behaviour.[Internet].2004 feb[cited 2006 sep]; volume 29.

17. R Snehalatha, M Bhagyalakshmi S Hemalatha (2017) A Study to Assess the Effectiveness of Structured Teaching Program on Knowledge Regarding Alcohol Use and Its Harmful Effects Among High School Children at Municipal Corporation School in Tirupati. New York, Penguin. J Drug Abuse Vol.3 No.3:25

NET REFERENCES

- http:// Psycho edu/script.htm
- http:// alcoholism/fags.shtml
- www:// Psychi info/script.htm
- https://casaa.unm.edu/inst/SOCRATESv8.pdf
- www://emedicine. Medscape.com
- www://alcohol abuse .com
- www://nlm.nih.gov/medline plus/
- www://mywayout.org.alcoholism.html/
- http:// Pschescap.com
- http://www.who.int/substance_abuse/publications/global_alcohol_report/en/2014

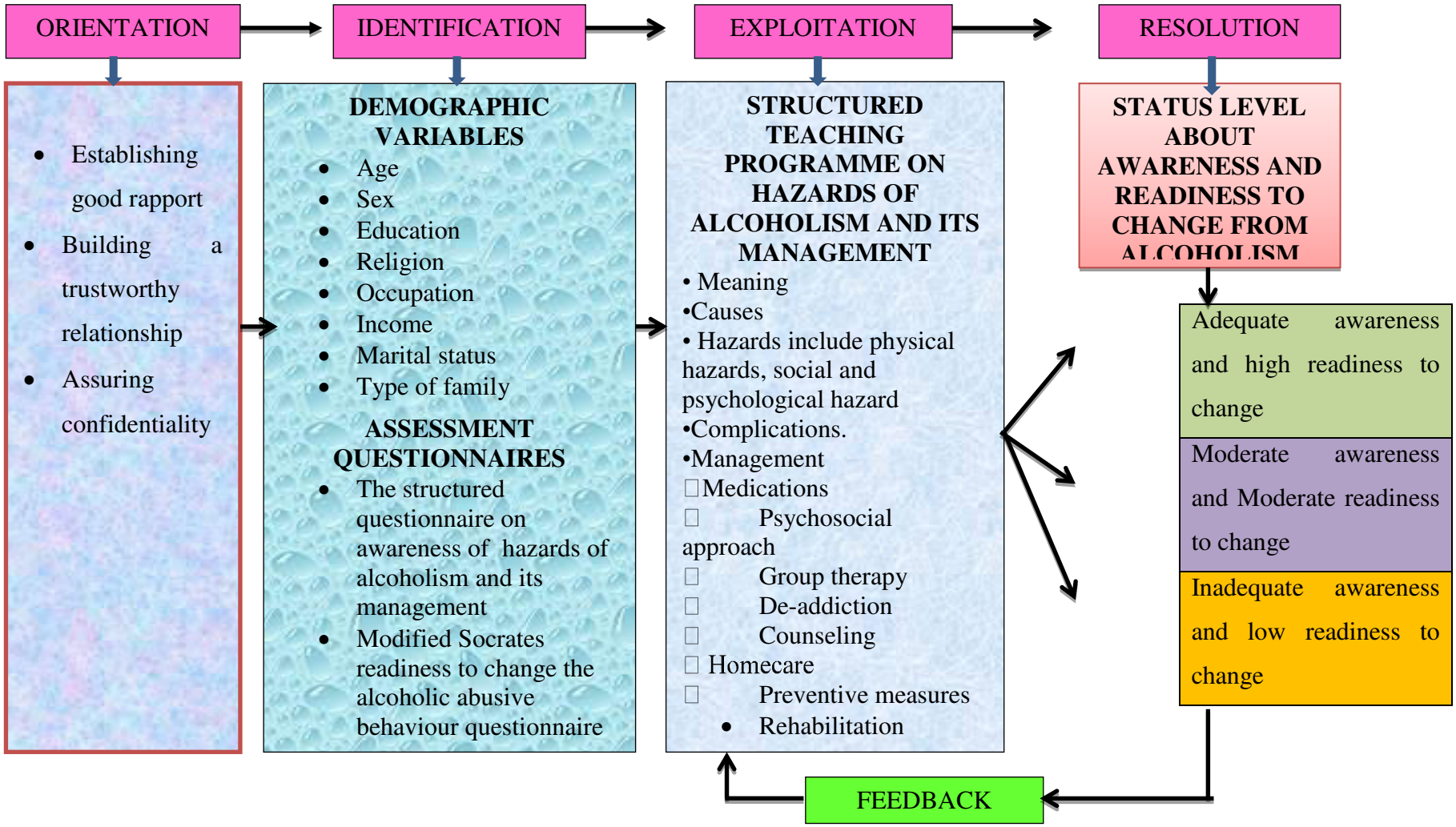


Figure1.1: MODIFIED E. HILDEGARD PEPLAU'S INTERPERSONAL THEORY (2011)

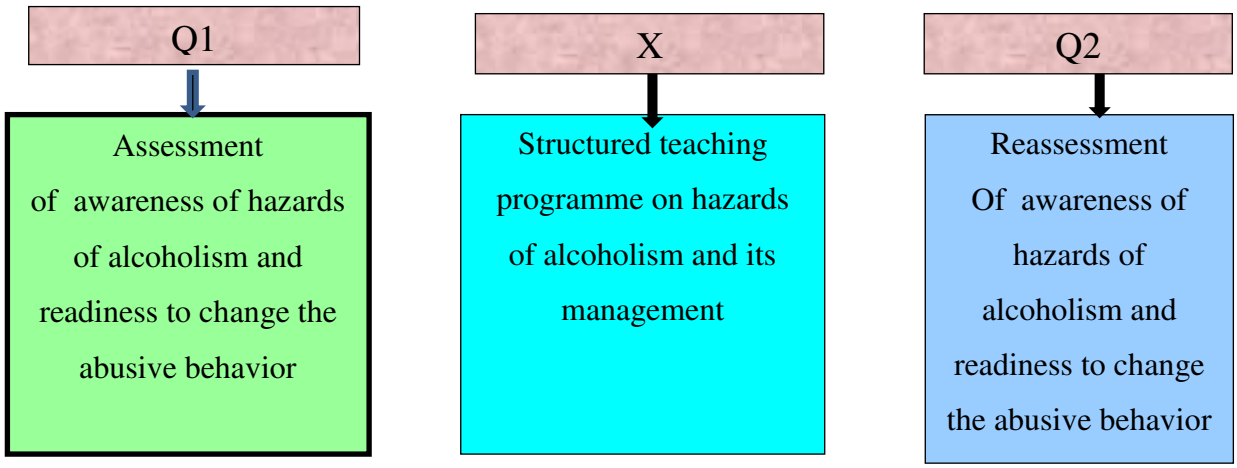


Figure: 3.1: The Schematic Representation of Research Design

3.4 RESEARCH VARIABLES

The Independent variable was a structured teaching programme regarding lifestyle modifications. The dependent variables were awareness of hazards of alcoholism and readiness to change the abusive behavior. Influencing variables were demographic variables.

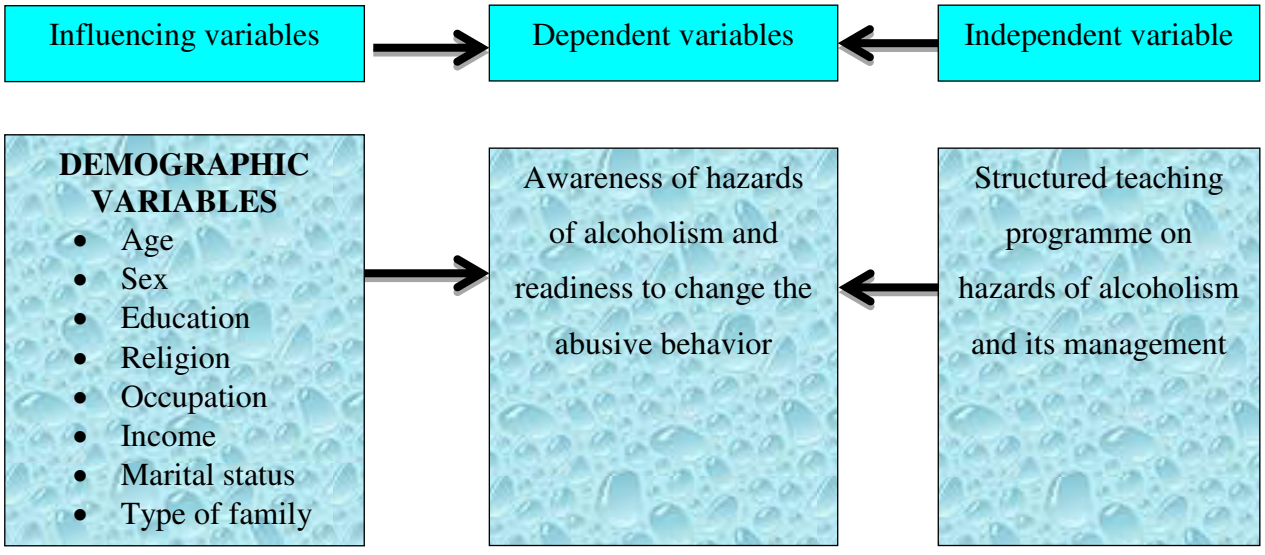


Figure 3.2: The Schematic Representation of Research variables

APPENDIX - II

Ref:

LETTER REQUESTING EXPERT OPINION TO ESTABLISH CONTENT VALIDITY

TO,

(Through- Principal Texcity College of Nursing)

Respected sir/madam,

SUB: Nsg-Education-MSc(N) II yr-content validity req-reg,

I wish to state that I am MSc (N) II year student of Texcity College of Nursing has to carry out a research project. This is to be submitted to the TN DR. MGR Medical University, Chennai in partial fulfillment for the requirement for the award of Master of Science in Nursing.

The topic of research project is:

"A study to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore".

I have enclosed,

1. Statement of the problem, objectives and hypothesis
2. Demographic data
3. Research tool
4. Teaching module

I request you to go through the items and give your valuable suggestions, modifications. additions and deletions, if any, in the remark column.

Thanking you,

Place: Coimbatore
Date:

Yours faithfully,

Ms.K.Banupriya

APPENDIX – III

LIST OF EXPERTS GIVEN OPENION FOR CONTENT VALITITY

1. **Mrs.K.Saranya,M.Sc(N).,(Psy)**
   Associate Professor,
   Texcity College of Nursing,
   Coimbatore.

2. **Mrs.K.P.Dhivyae prabha., M.Sc(N),(Psy)**
   Associate Professor,
   Texcity College of Nursing,
   Coimbatore.

3. **Mrs.J.Jansi Jancy., M.Sc(N),(Psy)**
   Asst.Professor,
   Kaveri College of Nursing
   Trichy.

4. **Dr.Mrs.Hemalatha Rajmohan.M.B.B.S.DPM.**
   Consultant Psychiatrist,
   Kurinchi Hospital,
   Coimbatore.

5. **Dr.Mrs.A.Vasanthi.MBBS.,DPM.,**
   Consultant Psychiatrist,
   Vazhikatti Mental Health Hospital & Research Institute,
   Coimbatore.

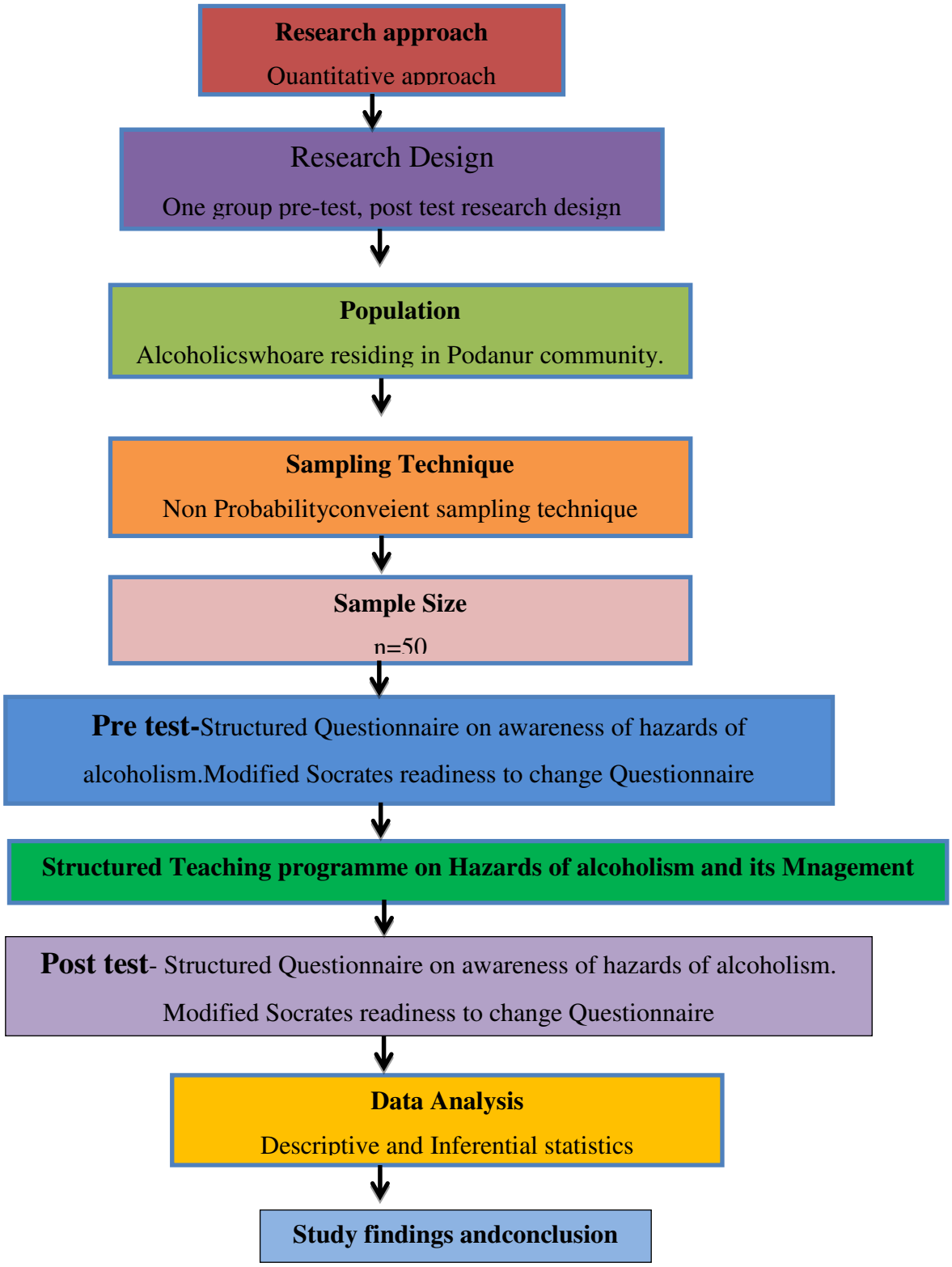


Figure 3.3 The schematic representation of Research Methoddology

TEXCITY COLLEGE OF NURSING

Podanur Main Road, Coimbatore - 641 023.
Phone : 0422 - 2410854, 2410443 E-mail : texcitycollege@yahoo.co.in.
Approved by the Government of Tamilnadu Vide G.O. MS. No. 226/22-09-2006 & INC
INC Code - B.Sc. (N) 2903067, M.Sc. (N) 2904079
Affiliated to TN Dr. MGR Medical University

Ref : **PERMISSION LETTER FOR CONDUCTING THE STUDY** Date:.....

From

K.BanuPriya,
M.Sc(N) II Year
Texcity College of Nursing
Coimbatore-641023

To

The Village Administrative Officer,
Kurichi,Podanur,
Coimbatore-641023

Through: Principal, Texcity College of Nursing.

SUB: Requisition letter for conducting the research study,

Respected madam,

I am, Mrs. K.BanuPriya,.M.Sc(N) II year in Texcity College of Nursing. Our Institution is affiliated to Tamilnadu DR.MGR. Medical University, Chennai, as part of my curriculum requirement of M.Sc(N) programme. I have to conduct a research study on , "A study to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore".

So, I kindly request you to grant me permission for conducting the study in this itteri area, in the month of feb- march. I assure you that I will not disturb the public routines and the information collected from the study participants will not be disclosed.

Thanking you,

Coimbatore your's faithfully,

Date: 08/01/2018

PRINCIPAL
TEXCITY COLLEGE OF NURSING
Podanur Main Road, Podanur,
Coimbatore - 641 023

K.BanuPriya

APENDIX IV

EVALUATION CRITERIA CHECK LIST FOR CONTENT VALIDITY

Introduction:

Expert is requested to go through the following evaluation criteria checklist prepared for the intervention there are three columns given for the response and facilitate suggestions in the remarks column given.

S. NO	CONTENT	CRITERIA			REMARK
		MET	PARTIALLY MET	DOES NOT MET	
I.	**SELECTION OF CONTENT :**				
a.	Content reflects the objectives				
b.	Content has up to date knowledge				
c.	Content is comprehensive for the learning needs				
d.	Content provide correct and accurate information				
e.	Content coverage				
II.	**ORGANIZATION OF CONTENT :**				
a.	Logical sequence				
b.	Continuity				
c.	Integration				
III.	**LANGUAGE :**				
a.	Local language is used in simple and in understandable dialogues				
b.	Technical terms are explained at the level of learners ability				
IV.	**FEASIBILITY \ PRACTICABILITY**				
a.	Is suitable to subjects				

b.	Permit self learning				
c.	Acceptable and useful to the clients				
d.	Suitable for setting				
V.	**ANY OTHER SUGGESTIONS**				

EXPERT'S SIGNATURE WITH DATE AND SEAL

APPENDIX - V

EVALUATION CRITERIA CHECK LIST FOR CONTENT VALIDITY

TOOL: 1 DEMOGRAPHIC VARIABLIES AND BACK GROUND INFORMATION

INSTRUCTION:

Expert is requested to go through the following evaluation criteria and check list prepared for the demographic variable there are three columns given for the response and facilitate suggestions in the remarks column given.

Demographic variables	Relevant	Irrelevant	Remarks
1-12			

Any other suggestions:

Expert's Signature with Date and Seal

APPENDIX VI

LETTER SEEKING CONSENT OF SUBJECTS FOR

PARTICIPATION IN THIS STUDY

SAMPLE NO:1

CONSENT LETTER

I,Mrs. ---------- willing to participate in the study to "A study to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore.".as part of M.Sc., Nursing requirements by Ms.Banu Priya. The study was well explained by the researcher and I am interested to take part in this study.

SIGNATURE

APPENDIX VII

CERTIFICATE FOR ENGLISH EDITING

TO WHOM SO EVER IT MAY CONCERN

This is to certify that the tool developed by Ms.Banu Priya, M.Sc., Nursing student of Texcity college of nursing for dissertation **"**A study to assess the effectiveness of structured teaching programme on awareness and readiness to change the abusive behavior among persons with alcohol use in the selected community at Coimbatore. and the study is edited for English language appropriateness by Mrs.Muthumalini Alice,M.A (English).,B.Ed. Texcity College of Nursing Coimbatore.

SIGNATURE

APPENDIX- VIII

TOOL-I

DEMOGRAPHIC VARIABLES

Instructions: Read the following questions carefully and give tick [✓] in a given box for the correct answers.

Sample No : _____

1. **Age in Years**
   a. <20 years ☐
   b. 21-40 years ☐
   c. 41-60 years ☐
   d. Above 60 years ☐

2. **Gender**
   a. Male ☐
   b. Female ☐

3. **Religion**
   a. Hindu ☐
   b. Muslim ☐
   c. Christian ☐

4. **Education**
   a. Illiterate ☐
   b. Primary education ☐

c. Secondary education ☐

d. Graduation ☐

5. Occupational status

a. Unemployed /student ☐

b. Self-employed ☐

c. Employed in the private sector ☐

d. Employed in the government sector ☐

6. Income/month

a. Less than RS.3000 ☐

b. Rs 3001-Rs.10,000 ☐

c. Rs.10,000-Rs.20,000 ☐

d. Above Rs.20,000 ☐

7.Marital status

a. Unmarried ☐

b. Married ☐

a. Widow/Widower ☐

b. Divorced/Separated ☐

8. Type of family

1. Nuclear ☐
2. Joint ☐

APPENDIX- X

TOOL-III

MODIFIED SOCRATES READINESS TO CHANGE QUESTIONNAIRE

Instructions: Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drinking. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for every statement**.**

Statements	Strongly Disagree	Agree	Undecided	Disagree	Stronglydisagree
1. I really want to make changes in my drinking.	1	2	3	4	5
2. Sometimes I wonder if I am an alcoholic	1	2	3	4	5
3. If I don't change my drinking soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drinking.	1	2	3	4	5
5. I was drinking too much at one time, but I've managed to change my drinking.	1	2	3	4	5
6. Sometimes I wonder if my drinking is hurting other people.	1	2	3	4	5
7. I am a problem drinker.	1	2	3	4	5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1	2	3	4	5

9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern	1	2	3	4	5
10. I have serious problems with drinking	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drinking.	1	2	3	4	5
12. My drinking is causing a lot of harm	1	2	3	4	5
13. I am actively doing things now to cut down or stop drinking.	1	2	3	4	5
14. I want help to keep from going back to the drinking problems that I had before.	1	2	3	4	5
15. I know that I have a drinking problem.	1	2	3	4	5
16. There are times when I wonder if I drink too much.	1	2	3	4	5
17. I am an alcoholic	1	2	3	4	5
18. I am working hard to change my drinking	1	2	3	4	5
19. People annoyingme by criticizing my drinking	1	2	3	4	5
20.I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	1	2	3	4	5

Scoring Key:

Grading of changes to readiness in alcohol abusers:

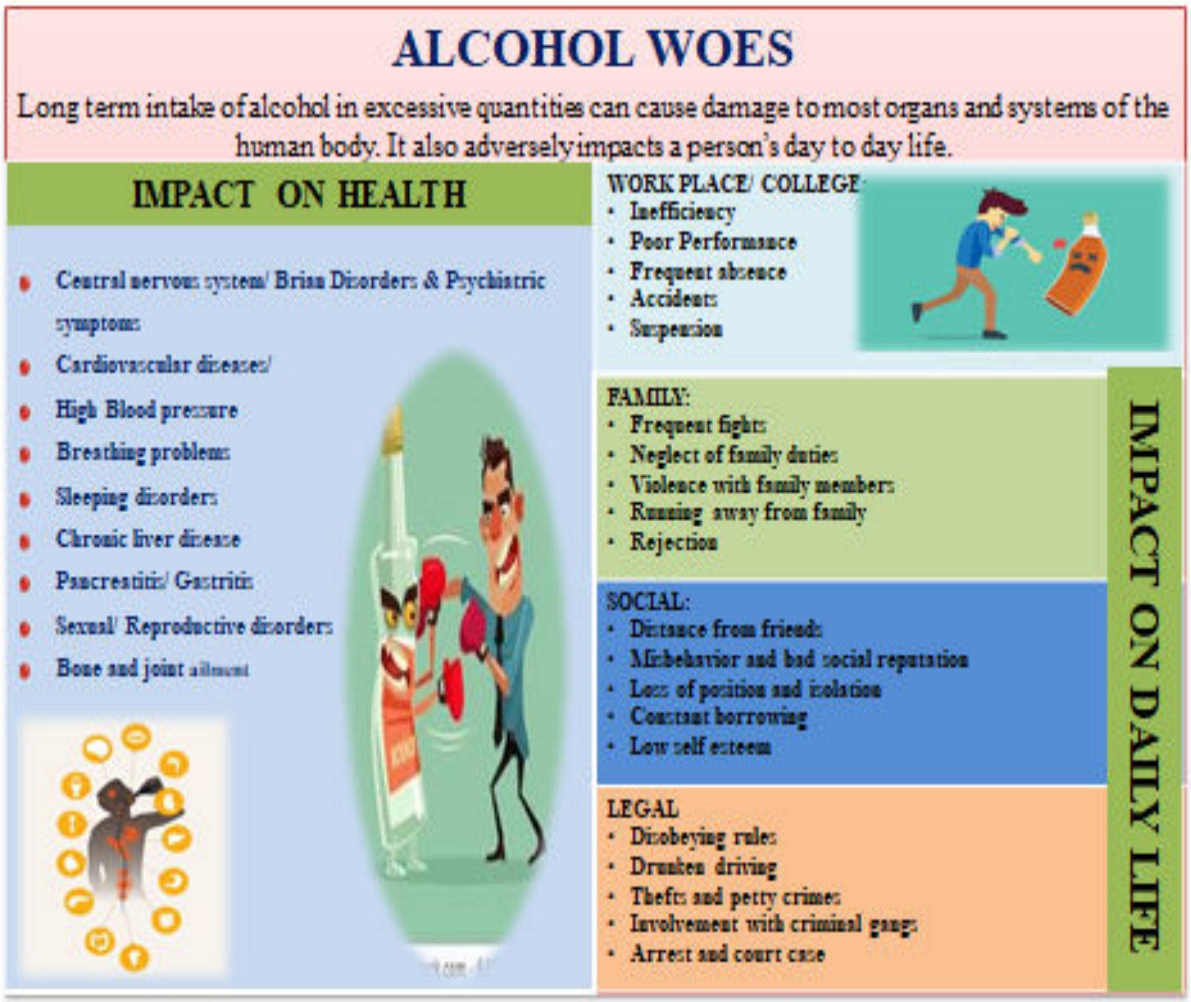
S.No	Changes to Readiness	Statement Score
1.	Strongly agree	5
2.	Agree	4
3.	Undecided	3
4.	Disagree	2
5.	Strongly disagree	1

Interpretation of changes to readiness in alcohol abusers

S.No	Interpretation of changes toReadiness	
1.	High readiness to change	70 and above
2.	Moderate readiness to change	40-69
3.	Low readiness to change	20-39

APPENDIX- XI

POSTER



APENDIX-XI

LESSON PLAN ON

HAZARDS OF ALCOHOLISM AND ITS MANAGEMENT

SUBMITTED BY:

MS.BANUPRIYA

Msc (N) II YEAR

Title of the course	: M.sc. Nursing
Subject	: Mental health nursing
Topic	: Hazards of alcoholism and its management
presented by	: Ms. Banu priya
Duration	: 45 minutes
Listeners	: Alcoholics
Method of teaching	: lecture cum discussion
Audio visual aids	: pamphlets, posters
Venue	: Podanur panchayat Board
Date	:
Time	:

GENERAL OBJECTIVES:

At the end of the session the alcoholics will gain adequate knowledge regarding the hazards of alcoholism and its management and develop their positive attitudes towards it and improve their skills in their future practices.

SPECIFIC OBJECTIVES:

The listener will be able to

- explain the meaning of 'alcoholism'
- describe the causes
- identify the risk factors
- Understand what happens to alcohol in the body?
- Describe the factors influencing alcohol absorption
- eaplain how alcohol leaves the body
- illustrate the hazards include physical hazards, social psychological, and legal hazard
- understand the withdrawal symptoms
- enumerate the complications of alcoholism
- discuss the Management of alcoholism
- explain rehabilitation.

S. No	Dur ation	Specific objectives	Content	Teacher and learner's activity	AV aids	Evaluation
	1mt		**Introduction** The word alcohol comes from the Arabic "Al Kohl," which means "the essence." Alcohol has always been associated with rites of passages such as weddings and graduations, social occasions, sporting events and parties. The media has often glamorized drinking. The reality is that alcohol is often abused because it initially offers a very tantalizing promise. As an individual's drinking progresses, however, it takes more and more alcohol to achieve the same high.	Explaining Listening		
1.	1mt	Explain the meaning of 'alcoholism'	**Alcoholism Meaning:** Addiction to the consumption of alcoholic drink; alcohol dependency**.**	Explaining Listening		What is 'alcoholism'?
2	2mts	Describe the causes	**Causes:** The cause of alcohol use disorder is still	Explaining Listening		What are all the causes of alcoholism?

			unknown. Alcohol use disorder develops when you drink so much that chemical changes in the brain occur. These changes increase the pleasurable feelings you get when you drink alcohol. This makes you want to drink more often, even if it causes harm.	Discussion		
3	2mts	Identify the risk factors	**Risk Factors:** • Stressful job, for example, doctors and nurses – their day-to-day lives can be extremely stressful. • Drinking at an early age due to peer pressure • Mental health problems like depression Anxiety, depression, bipolar disorder. • Taking alcohol with medicine • Family history • low self-esteem • Spending time around people who drink heavily or abuse alcohol	Explaining Listening	Chart	What are all the risk factors ?
4	3mts	Understand what		Explaining		

		happens to alcohol in the body?	**What happens to alcohol in the body**? When someone swallows alcohol, it travels to the stomach and small intestine. The alcohol is absorbed through the lining of the stomach and intestine and passes into the bloodstream. It circulates to other parts of the body, including the brain.	Listening		What happens to alcohol in the body?
5	3mts	Describe the factors influencing alcohol absorption.	**How quickly the alcohol is absorbed, and how much goes into the blood, depends on a number of factors including:** • the amount and type of alcohol in the drink • how quickly the person is drinking • whether they have a full or empty stomach (food slows down the absorption of • alcohol into the bloodstream) • body size and weight (the same amount of alcohol will have a larger effect on a • smaller person) • male or female (alcohol is distributed around the body in water - the female • body has more body fat and less water than	Explaining Listening		What are all the factors influencing alcohol absorption?

			the male body so alcohol • concentrations tend to be higher in females).The amount of alcohol in someone's blood is measured by their BAC (blood alcohol concentration). BAC is usually measured as the number of milligrams (mg) of alcohol in 100 millilitres (ml) of blood. Most of the alcohol a person drinks is metabolised (broken down) by the liver. It can break down about 8g of alcohol an hour in an average adult - that's around 1 unit an hour. Because the liver is the main organ breaking down alcohol, it's also one of the first parts of the body to be harmed by heavy drinking. Longterm drinking kills off liver cells, leading to a disease called 'cirrhosis'. Long term excessive drinking can also lead to liver cancer.			
6	3mts	Explain how alcohol leaves the body	**How alcohol leaves the body** • Liver: about 90% of the alcohol is broken down by the liver	Explaining Listening	Chart	How alcohol leaves the body?

			• Kidneys: 2-4% leaves the body in urine made by the kidneys • Sweat glands: 2-6% leaves in perspiration from sweat glands • Lungs: 2-4% is expired in the breath • Mouth: 1-2% leaves in saliva			
7	7mts	Illustrate the hazards include physical hazards, social psychological, and legal hazards	**Hazards** **1.PHYSICAL:** **Short term effects:** • Slurred speech • Difficulty standing up or walking • Looking flushed • Feeling sick • Needing to urinate more (less antidiuretic • hormone secreted) • Loss of self-control • Slow reactions • Dehydration leading to a 'hangover' • Blurred vision	Explaining Listening	Poster	What are all the physical hazards of alcoholism?

			• Breath smelling of alcohol **Long term effects:** • Cirrhosis and cancer • Ulcers • Depression and mood swings • Urinary infections • Memory loss • Bloodshot eyes • High blood pressure • Mental illness • Flushed complexion • Rapid pulse • Breathing problems • Vomiting and diarrhoea • Dehydration • Chronic liver disease • Sexual/ Reproductive disorder **2.PSYCHOLOGICAL HAZARD:** WORK PLACE/ COLLEGE:			What are all the Psychological, hazards of

			• Inefficiency • Poor Performance • Frequent absence • Accidents • Suspension FAMILY: • Frequent fights • Neglect of family duties • Violence with family members • Running away from family • Rejection **3.SOCIAL HAZARD:** • Distance from friends • Misbehavior and bad social reputation • Loss of position and isolation • Constant borrowing • Low self esteem **4.LEGAL HAZARD**			alcoholism? What are all the social Hazards of alcoholism? What are all thelegal

			• Disobeying rules • Drunken driving • Thefts and petty crimes • Involvement with criminal gangs • Arrest and court case			hazard hazards of alcoholism?
8	4mts	understand the withdrawal symptoms	**SYMPTOMS OF ALCOHOL WITHDRAWAL :** • Agitation, restlessness • Anorexia nervosa • Anxiety, panic attacks, fear, irritability, depression • Catatonia • Confusion • Delirium tremens • Derealization • Euphoria • Fever • Gastrointestinal upset, nausea and vomiting, diarrhea • Hallucinations • Headache, migraine	Explaining Listening Discussion	Chart	What are all the the withdrawal symptoms?

9	4mts	Enumerate the complications of alcoholism	• High blood pressure • Insomnia, increased REM sleep • Palpitations, tachycardia • Psychosis • Seizures and death • Sweating • Tremors • Weakness **COMPLICATIONS:** • Alcohol actually reduces levels of these Serotonin and dopamine chemicals • At higher doses, it quickly becomes apparent that alcohol is in fact toxic. • Even non-lethal doses can kill. • Anyone who drinks alcohol after going a long time without food can have an attack of hypoglycemia, • Long-term heavy drinking can cause a range of chronic problems. • Drinking during pregnancy has been shown to	Explaining Listening		What are all the complications of alcoholism?

10	7mts	discuss the Management of alcoholism	have a negative effect on babies. **MANAGEMENT:** **DE ADDICTION:** **De-toxification:** The first step in treating alcoholism is accepting that you have a problem. Confronting an addiction and accepting that drinking is having a negative impact on your life isn't easy. But it's a necessary step on the road to recovery. Optimal treatment plan will depend on person's personal circumstances, it includes: 1. prior history of alcohol dependence 2. level of support from family and friends 3. personal commitment to becoming and remaining sober 4. financial situation **1.MEDICATIONS:** 1. **Disulfiram** is used as a conditioning treatment for alcohol dependence.The most common side effect of disulfiram includes drowsiness and	Explaining Listening Discussion	Pamphlet	What are all the Management of alcoholism? What is the side effect of Dulfiram?

			fatigue . Disulfiram therapy should be started only after the patient has abstained from alcohol for at least 12 hours. The initial dose may be as high as 500 mg taken once daily. If the medication is sedating, the dose can be administered in the evening. Ideally, though, the daily dose should be taken in the morning—the time the resolve not to drink may be strongest. The initial dosing period can last for one to two weeks. Maintenance dose can range anywhere from 125–500 mg daily with the average dose being 250 mg daily. Disulfiram therapy should continue until full recovery. This may take months to years, depending upon patient's response and motivation to stop using alcohol. The duration of disulfiram's activity is 14 days after discontinuation, and patients need to avoid alcohol for this period of time. **2. Naltrexone**: which blocks the feel-good effects that alcohol has on your brain. Without those good feelings, you may feel less inclined to drink.Naltrexone can cause liver problems when given			

			in doses that are too large. Stop using this medication and notify your doctor immediately if symptoms of liver problems develop, such as abdominal or stomach pain, yellowing eyes or skin, or dark urine. **2. PSYCHOSOCIAL APPROACH:** Look for a licensed mental health professional with experience working with adult children of alcoholics or with addressing trauma. They help the alcoholics to change their behavior. **Stages of behavior change:** • **Precontemplation (Not Ready)** unaware of risk behavior consequences; not ready for change. • **Contemplation (Getting Ready)** aware of potential problem; weighing pros and cons of change; ambivalence • **Preparation (Ready)** intention to take action; making plans for change • **Action:** engagement in observable behaviours			What is contemplation stages ?

			sufficient to reduce risk • **Maintenance:** maintaining commitment to change: routinely initiating change in lifestyle. • Termination: change behaviors have become routinized; no return to risk behaviors even during stress or times that would have previously triggered them. **a. Group therapy**: A form of psychotherapy in which patients meet to describe and discuss their problems. • **Psychoeducational groups** that learn about the mechanics of addiction and substance abuse. • **Skills development groups** that develop the techniques and strategies essential for beating an addiction. • **Cognitive-behavioral groups** that learn to replace harmful ways of behaving and thinking with healthier ways. • **Support groups** that enable participants to support one another in making constructive changes. Al-Anon is a free support group for			What are all the types of group therapy?

			family members and friends of people with alcoholism. It uses a 12-step program. • **Interpersonal process groups** that help members reconstruct their past in the present moment and rethink their problems without the impediment of psychoactive substances. **Advantages of group therapy:** • Positive peer support and pressure to remain abstinent. • Members of group therapy hold each other accountable for attending each session, arriving on time, and actively participating in order to ensure everyone benefits from the session. • Reduced feelings of isolation. • Hope for recovery • Support and encouragement during difficult times. • Structure and discipline. • Practice putting new social skills to work in a safe environment. • Members helping other members confront their			

			own denial and break down barriers to treatment. • A built-in social network of other non-users. **3. COUNSELING:** One of the most effective forms of alcoholism treatment is cognitive behavioural therapy (CBT). This form of counselling tackles patterns of thinking and behaviour in an attempt to break certain emotional or psychological ties to habits. Planned withdrawal from alcohol, which can help people to safely stop drinking. By understanding the underlying feelings and thought processes that cause their addiction, alcoholics can gradually learn to control the impulse to drink.Soon, they will find new ways to address their problems and insecurities, without having to turn to alcohol. Counsellors can offer the professional support and guidance that struggling alcoholics need to turn their lives around.Your doctor may also refer you to one-on-one or group counseling. Support groups can be especially helpful when you're going through			

			treatment for alcohol addiction. A support group can help you connect with other people who are facing similar challenges. They can help answer questions, provide encouragement, and direct you to support resources. **4. HOME CARE AND PREVENTIVE MEASURES** DO'S AND DONT'S For the alcoholics: **Do's** • Set goals and prepare for change • forgive • Be honest with yourself • Be Humble • Take it Easy – Tension is Harmful • Play – Find recreation and hobbies • Keep on Trying whenever you fail • Learn all the facts about Alcoholism • Attend Alanon meetings often • Pray			

			• Reward your self • Track your alcohol conception • Avoid temptation by choosing non-alcoholic drinks that look like alcoholic ones. For example, tomato juice, lemonade, iced tea, or water with ice cubes **DON'T…** • Be Self-Righteous, • Try to dominate, nag, scold or complain • Lose Your Temper • Try to push anyone but yourself • Keep bringing up the past • Keep checking up on your alcoholic • Wallow in self-pity • Make threats you don't intend to carry out • Be over-protective • Be a doormat **DO'S AND DONT'S For the family members of alcoholics:**			

			• Do learn facts about alcoholism • Do develop an attitude to match the facts • Do talk to someone who understands alcoholism • Do take a personal inventory of yourself • Do go to the clinic of AA • Do maintain a healthy atmosphere in your home • Do encourage their new interests • Do take relapse lightly if there is one • Do pass your knowledge of alcoholism to others. • Don't preach and lecture • Don't have " holier –than thou" attitude • Don't use the " if you love me" appeal • Don't make threats you won't carry out • Don't hide his liquor and pour it out. • Don't argue with him if he is drunk • Don't's make an issue over treatment • Don't expect an immediate 100% revcovery • Don't be jealous of his method of recovery			

11	3mts	Explain the goals of Rehabilitat**ion.**	• Don't try to protect him against alcohol. **REHABILITATION**: Alcohol rehabilitation is the process of combining medical and psychotherapeutic treatments to address dependency on alcohol **Alcohol Rehabilitation Goals:** • Goal 1: End alcohol abuse • Goal 2: Establish a positive support system • Goal 3: Improve general health • Goal 4: Improve personal circumstances • Goal 5: Meet employment and educational needs • Goal 6: Reduce criminal behavior and resolve legal problems • Goal 7: Treat psychiatric disorders and psychological problems. **What Happens During Alcohol Rehabilitation?** 1. First, assessment	Explaining Listening Discussion		What are all the goals of rehabilitation.

			2. Then, alcohol detox if necessary 3. The meat of the program (psychotherapy and behavioral treatments) 4. Prescription medications 5. Continuing alcoholism education 6. Finally, supportive social services **What Happens After Alcohol Rehabilitation?** After alcohol rehabilitation, you're pretty much on your own. While aftercare is getting significantly better, it will be up to you to continue a program of rigorous attention to your inner life. A good alcohol rehabilitation program may recommend you to: • a community addiction recovery center • life skills training programs • outpatient addiction treatment • social services • transitional living **SUMMARY:** So far we hve discussed about 'alcoholism',			

	3 mts		causes, risk factors, what happens to alcohol in the body?, factors influencing alcohol absorption, how alcohol leaves the body, hazards include physical hazards, social psychological, and legal hazard, withdrawal symptoms, complications, Management and rehabilitation. **.CONCLUSION:** I hope that all of you understood about the hazards of alcoholism and its management. **REFERENCES:** 1.Mascott, C. (2016). An Introduction to Alcoholism. Psych Central. Retrieved on August 25, 2018, from https://psychcentral.com/lib/alcoholism-and-its-treatment/ 2. Mayo Clinic Staff. (2015, July 25). Alcohol use disorder mayoclinic.org/diseases-conditions/alcohol-use-			

			disorder/basics/treatment/con-20020866 3. Understanding alcohol use disorders and their treatment. (2012, March) apa.org/helpcenter/alcohol-disorders.aspx **Net reference:** https://addictionblog.org/rehab/rehabilitation/what-is-alcohol-rehabilitation/			

APPENDIX- IX

TOOL-II

STRUCTURED QUESTIONNAIRE ON AWARENESS OF HAZARDS OF ALCOHOLISM

Instructions: Read the following questions carefully and give tick [✓] in the correct answers.

Sample No : _____

1.Which of these factors contributes to alcohol-use disorder?

a) Family history of alcoholism
b) Environment
c) A and B
d) None of the above

2. Alcohol-use disorder increases your risk for:

a) Cancer
b) Pancreatitis
c) Liver damage
d) All of the above

3. What can you do to drink less?

a) Keep a track of when you drink
b) Space out your alcoholic beverages
c) Designate alcohol-free days
d) All of the above

4Which organ is responsible for breaking down the 90% of consuming alcohol?

a) Liver
b) Kidneys
c) Lungs
d) Sweat glands

5.How long does it take to have enough alcohol in your blood to measure?

a) 5 minutes
b) 30 minutes
c) 45 minutes
d) 1 hour

6. Which of the following is the short term effects of alcohol?

a) Mental illness
b) Cancer
c) Breath smelling of alcohol
d) Ulcers

7.Which of the following is the short term effects of alcohol except?

a) Loss of self-control
b) Cirrhosis of liver
c) Looking flushed
d) Feeling sick

8. Which of these symptoms is considered as withdrawal symptoms?

a) Headache
b) Tremors
c) Sweating
d) All of the above

9.Person who drinks alcohol after going a long time without food can have the following symptom--------

a) Hypoglycemia
b) High blood pressure
c) Hallucinations
d) None of the above

10. Which of the following statement is correct about alcohol?

a) Long-term heavy drinking can cause a range of chronic problems.
b) Alcohol reduces the levels Serotonin and dopamine chemicals
c) Both A& B
d) None of the above

11.The duration of disulfiram's activity after discontinuation is -------

a) 8 days
b) 3 days
c) 6 days
d) 14 days

12.Which blocks the feel-good effects that alcohol has on your brain?

a) Naltrexone
b) Disulfiram
c) Both A & B
d) None of the above

13. What is a pre contemplation stage in changes of behavior?

a) Not ready for change.
b) Getting ready for change
c) Ready for change
d) None of the above

14. Which of the following statement about Disulfiram therapy is true?

a) Disulfiram therapy should be started only after the patient has abstained from alcohol for at least 12 hours
b) Disulfiram therapy can be stopped by the person before full recovery
c) The most common side effect of Disulfiram includes drowsiness and fatigue
d) Both A & C

15.What will you do when you take Naltrexone if symptoms of liver problems develop, such as abdominal or stomach pain?

a) Stop using this medication and notify your doctor immediately
b) Wait until the next dose of medication
c) Take half of the dose of medication
d) No concern is needed, because it is a common side effect of this medication.

16.What is the focused role of Skills development groups?

a) It develops the techniques and strategies essential for beating an addiction.
b) It helps to replace harmful ways of behaving and thinking with healthier ways.
c) It enables participants to support one another in making constructive changes.
d) Noneof the above

17.What is the advantage of group therapy?

e) Support and encouragement during difficult times.
f) Structure and discipline.
g) Practice putting new social skills to work in a safe environment.
h) All of the above

18. What should alcoholicsexpected to do during de addiction except?

a) Take it Easy – Tension is Harmful
b) Play – Find recreation and hobbies
c) Keep on Trying whenever you fail
d) Lose temper

19. How should alcoholics avoid temptation for alcohol?

a) Choosing non-alcoholic drinks that look like alcoholic ones
b) Try to avoid parties with alcohol
c) Find recreation and other hobbies to indulge.
d) All the above

20.What Happens During Alcohol Rehabilitation?

a) First, assessment, then, alcohol detox if necessary
b) The meat of the program (psychotherapy and behavioral treatments)
c) Continuing alcoholism education, supportive social services
d) All of the above.

21. What is Insomina?

a) Trouble falling sleep
b) Day time sleep
c) Napping
d) Feeling irritable

22. What is hallucination?

a) It is a problem with writing
b) It is a problem with thinking
c) It a problem with speaking
d) It is a problem with intelligence

23. What are all the effects of chronic alcoholism on family?

a) Neglect of family duties
b) Violence with family members
c) Running away from family
d) Allof the above

24.Which of the following statement is not true about alcohol absorption?

a) The amount and type of alcohol in the drink influence the alcohol absorption
b) Food increase the absorption of alcohol into the bloodstream
c) The same amount of alcohol will have a larger effect on a smaller person
d) A & C

25.BAC is usually measured as the number of milligrams (mg) of alcohol in ---------- -- (ml) of blood.

a) 100ml of blood
b) 1000 ml of blood
c) 10 ml of blood
d) None of the above

26.TheLiver can break down about ---------- of alcohol an hour in an average adult

a) 8 gm
b) 5 gm
c) 12 gm
d) 6 gm

27. Alcohol means

a) Essence
b) Good
c) Real
d) High

28. What is name of the disease caused by alcohol in the liver?

a) Ulcer
b) gastritis
c) Cirrhosis
d) Mucositis

29.Which of the following symptoms is most worrisome in a patient undergoing alcohol withdrawal?

a) Bradycardia
b) Delirium tremens
c) Tachycardia
d) Agitation

30. Prolonged alcohol abuse can result in a severe deficiency in what vitamin?

a) Vitamin C
b) Niacin (B3)
c) Thiamine (B1)
d) Folate

Scoring Key:

1.	c	**16**	a
2.	d	**17.**	d
3.	d	**18.**	d
4.	a	**19.**	d
5.	a	**20.**	d
6.	c	**21.**	a
7.	b	**22.**	b
8.	d	**23.**	d
9.	a	**24.**	b
10.	c	**25.**	a
11.	d	**26.**	a
12.	a	**27.**	a
13.	a	**28.**	c
14.	d	**29.**	b
15.	a	**30.**	c

- **Correct answer- one mark,**
- **Wrong answer - zero marks.**
- **The possible maximum score was 30**

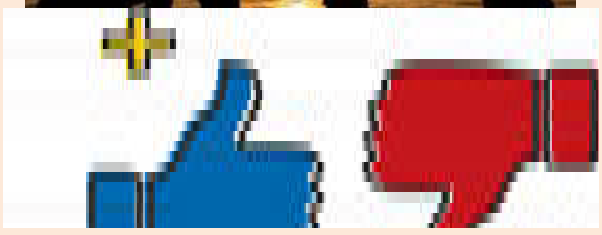
Interpretation of score:

S.No	Status of Awareness	Score
1.	Adequate awareness,	21-30
2.	Moderate awareness	11- 20
3.	Low awareness	0- 10

APENDIX XII

- Don't preach and lecture
- Don't have " holier –than thou" attitude
- Don't use the " if you love me" appeal
- Don't make threats you won't carry out
- Don't hide his liquor and pour it out.
- Don't argue with him if he is drunk
- Don't's make an issue over treatment
- Don't expect an immediate 100% revcovery
- Don't be jealous of his method of recovery
- Don't try to protect him against alcohol.

DO'S AND DON'TS FOR ALCOHOLICS& THEIR FAMILIES



DO'S AND DONT'S FOR THE ALCOHOLICS

- Forgive
- Set goals and prepare for change
- Be honest with yourself
- Be Humble
- Take it Easy – Tension is Harmful
- Play – Find recreation and hobbies
- Keep on Trying whenever you fail
- Learn all the facts about Alcoholism
- Attend Alanon meetings often
- Pray
- Reward your self
- Track your alcohol conception
- Avoid temptation by choosing non-alcoholic drinks that look like alcoholic ones. For example, tomato juice, lemonade, iced tea, or water with ice cubes

DON'TS…

- Be Self-Righteous,
- Try to dominate, nag, scold or complain
- Lose Your Temper
- Try to push anyone but yourself
- Keep bringing up the past
- Keep checking up on your alcoholic
- Wallow in self-pity
- Make threats you don't intend to carry out
- Be over-protective
- Be a doormat

DO'S AND DONT'S FOR THE FAMILY MEMBERS OF ALCOHOLICS:

- Do learn facts about alcoholism
- Do develop an attitude to match the facts
- Do talk to someone who understands alcoholism
- Do take a personal inventory of yourself
- Do go to the clinic of AA
- Do maintain a healthy atmosphere in your home
- Do encourage their new interests
- Do take relapse lightly if there is one.